(3)

Supreme Court, U.S.
FILED
051350 APR 24 2006
OFFICE OF THE CLERK

No.

IN THE

Supreme Court of the United States

NEVA MURRAY, INDIVIDUALLY AND AS GUARDIAN OF HUGH MURRAY, WARD,

Petitioners

v.

CROSSMARK SALES, INC.;
CONNECTICUT GENERAL LIFE INSURANCE CO.; AND
GROUP & PENSION ADMINISTRATORS, INC.

Respondents

On Petition for a Writ of Certiorari To The United States Court of Appeals for the Fifth Circuit

---

PETITION FOR A WRIT OF CERTIORARI

EDWARD L. PINA
Counsel of Record
EDWARD L. PINA & ASSOCIATES
8118 DATAPOINT DRIVE
SAN ANTONIO, TEXAS 78229
(210) 614-6400

DANIEL Y. KRUGER
TERESA K. VALENTIC
JESSICA SELINKOFF

Counsel for Petitioners

QUESTIONS PRESENTED FOR REVIEW

(1) In the 17 years since this Court held, in *Firestone Tire and Rubber v. Bruch*, 489 U.S. 101, 110, 109 S.Ct. 948, 954 (1989), that the appropriate standard of review of benefit determinations of an ERISA administrator with discretion was abuse of discretion, this standard of review has proven untenable. Considering that ERISA claimants' state law claims for unfair claims practices are preempted, that statutory damages for ERISA administrators' procedural failures are limited and set to a 1970's standard of living, and that ERISA administrators now administer benefits with virtually no judicial review:

Should this Court reconsider the part of *Firestone v. Bruch* decision allowing for abuse of discretion review in ERISA cases?

(2) This Court has required the development of a federal common law of rights and obligations under ERISA-regulated plans. The Courts of Appeals are divided over the following question of federal common law under ERISA:

Whether ERISA plans must be interpreted and ERISA administrator decisions reviewed under the doctrine of "Reasonable Expectations"?

CERTIFICATE OF PARTIES TO THE PROCEEDIN(AND CORPORATE DISCLOSURE STATEMENT

The following listed persons have an interest in th outcome of this case. These representations are made in ord(that the justices of this Court may evaluate possibl disqualification or recusal. The parties to the proceedings belo· are Petitioners Neva Murray and Hugh Murray, ward, an Respondents Crossmark Sales, Inc., Connecticut General Lif Insurance Co., and Group & Pension Administrators, Inc.

Pursuant to Rule 29.6, Petitioners state that they ar natural persons and not corporations.

TABLE OF CONTENTS

Page

QUESTIONS PRESENTED i

CERTIFICATE OF PARTIES TO THE PROCEEDING AND CORPORATE DISCLOSURE STATEMENT ii

TABLE OF CONTENTS iii

TABLE OF AUTHORITIES v

PETITION FOR A WRIT OF CERTIORARI 1

OPINIONS BELOW 1

JURISDICTION 1

STATUTES AND REGULATIONS INVOLVED 1

STATEMENT OF THE CASE 2

A. Facts Relevant to Issues Presented for Review 2

B. Basis for Jurisdiction And Proceedings Below 6

REASONS FOR GRANTING THE PETITION.....8

A. Summary of the Argument 8

B. The Abuse of Discretion standard has proven untenable 9

C. The Fifth Circuit's rejection of the Reasonable Expectation Doctrine presents a conflict

between the
circuits.....13

CONCLUSION .....1(

APPENDICES
1. 5th Circuit Opinion.....App. 1
2. District Court Final Judgment, ...App. 7
3. District Court July 22, 2004 order.....App. 9
4. Additional Statutes and Regulations .....App. 23

TABLE OF AUTHORITIES

Page

CASES

Aetna Health, Inc. v. Davila, 542 U.S. 200, 124 S.Ct. 2488, 159 L.Ed.2d 312 (2004) 8

Brumm v. Bert Bell NFL Retirement Plan, 995 F.2d 1433 (8th Cir. 1993) 12

Burke v. Kodak Retirement Income Plan, 336 F.3d 103 (2nd Cir. 2003) 10, 11

Clark v. Metropolitan Life Ins. Co., 67 F.3d 299, WL 592102 (6th Cir. 1995) (unpublished) 11, 12

Confer v. Custom Engineering Co., 952 F.2d 41 (3rd Cir. 1991) 10

DiFelice v. Aetna U.S. Healthcare, 346 F.3d 442 (3rd Cir. 2003) 8

Donovan v. Dillignham, 688 F.2d 1367 (11th Cir. 1982) 11

Estate of Shockley v. Alyeska Pipeline Service Co., 130 F.3d 403 (9th Cir. 1997) 14

Firestone Tire and Rubber v. Bruch, 489 U.S. 101, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989) .....i, 8, 11, 12, 13

Frommert v. Conkright, 433 F.3d 254 (2nd Cir. 2006) 10

Gallagher v. Reliance Std. Life Ins. Co., 305 F.3d 264 (4th Cir. 2002) 13, 14

Garst v. Wal-Mart Stores, Inc., 30 Fed. Appx. 585 (6th Cir. 2002) (unpublished) 1

Heinglein v. Informal Plan for Plant Shutdown Benefits, 974 F.2d 391, 400 (3rd Cir. 1992) 11, 14

Hightshue v. AIG Life Ins. Co., 135 F.3d 1144 (7th Cir. 1998) 10, 1

Horn v. Cendant Operations, Inc., 69 Fed. Appx. 421 (10th Cir. 2003) (unreported) 1

Jebian v. Hewlett-Packard Co. Employee Benefits Org., Inc. Protection Plan, 349 F.3d 1098, 1105 (9th Cir. 2003).....12

Kimber v. Thiokol Corp., 196 F.3d 1092 (10th Cir. 1999) ...14

Kreutzer v. A.O. Smith Corp., 951 F.2d 739 (7th Cir. 1991)...9

Lifson v. INA Life Ins. Co. Of New York, 333 F.3d 349, 353 (2nd Cir. 2003) 14

McClure v. Life Ins. Co. Of N. Am., 84 F.3d 1129 (9th Cir. 1996) 14

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987) 13

Ruttenberg v. United States Life Ins. Co., 413 F.3d 652 (7th Cir. 2005) 14, 15

Saltarelli v. Bob Baker Group Medical Trust, 35 F.3d 382 (9th Cir. 1994).....14, 15

Tester v. Reliance Standard Life Ins. Co., 228 F.3d 372 (4th Cir. 2000) 14

VanderKlok v. Provident Life and Accident Ins. Co.,

956 F.2d 610 (6th Cir. 1992).....12.

Vega v. Nat'l Life Ins. Services, 188 F.3d 287, 297 (5th Cir. 1999) (*en banc*) 9

Wheeler v. Dynamic Engineering, Inc., 62 F.3d 634 (4th Cir. 1995) 14

Wood v. Prudential Ins. Co. of America, 207 F.3d 674 (3rd Cir. 2000) 8

STATUTES

28 U.S.C. § 1254(1) (2005).....1

29 U.S.C. § 1001, *et seq.* (2005).....1, 6, 15

29 U.S.C. § 1001(a) (2005).....1, 17

29 U.S.C. § 1001b(c) (2005).....2, 17

29 U.S.C. § 1022 (2005).....9, 10

29 U.S.C. § 1024(b) (2005).....9

29 U.S.C. § 1132 (a) (2005).....2

29 U.S.C. §1133 (2005).....12

Fed. R. Civ. Proc. Rule 8 .....7, 13

REGULATIONS

29 C.F.R. § 2520.104b-1 (2006).....9

29 C.F.R. § 2520.104b-3 (2006).....9

29 C.F.R. § 2520.107-1(b)(3) (2006)..... 9

29 C.F.R. § 2560.503-1(b)(5)2 (2006).....

29 C.F.R. § 2560.503-1(g) (2006).....9, 1

PETITION FOR A WRIT OF CERTIORARI

Petitioner Neva Murray, individually and as guardian of Hugh Murray, respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit in this case.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Fifth Circuit is unreported. The opinion of the United States District Court for the Western District of Texas is unreported. These opinions are included in the Appendix.

JURISDICTION

The United States Court of Appeals for the Fifth Circuit rendered judgment on January 23, 2006. This Petition for Writ of Certiorari is within 90 days of that date and is timely. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

29 U.S.C. § 1001(a) of The Employee Retirement Income and Security Act) ("ERISA") states that

> "owing to the lack of employee information and adequate safeguards concerning [benefit plan] operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans."

29 U.S.C. § 1001b(c) of ERISA states that "It is hereby declared to be the policy of this title * * * (3) to increase the likelihood that participants and beneficiaries . . . will receive their full benefits."

29 U.S.C. § 1132(a) of ERISA states that "[a] civil action may be brought * * * (1) by a participant or beneficiary * * * (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."

Relevant portions of ERISA, 29 U.S.C. § 1001, *et seq.*, together with relevant portions of the implementing regulations, are included in the Appendix.

STATEMENT OF THE CASE

A. Facts Relevant to Issues Presented for Review

Petitioner Neva Murray has received comprehensive major medical coverage through her employer, Respondent Crossmark Sales ("Crossmark") since 1996. This self-funded benefits plan was administered by Respondent Group & Pension Administrators ("GPA") through February, 2001. From March 1, 2001 to present, Respondent Connecticut General Life Insurance Co. ("CIGNA") has administered the plan.

Petitioner, when she first enrolled, received neither a Summary Plan Description ("SPD") nor a copy of the plan

itself,[1] but was provided an "enrollment guide," generally outlining plan benefits and requirements, but not exclusions. When the GPA plan benefits were amended in January, 1997 and January, 1999, Mrs. Murray again received brief summaries, but not full SPDs or information regarding exclusions. When CIGNA assumed administration, Mrs. Murray again received an "enrollment guide" regarding benefits under the CIGNA plan, but neither an SPD nor copy of the plan.

The evidence indicates that once CIGNA assumed administrative duties on March 1, 2001, it administered the Crossmark plan without benefit of any governing documents – whether SPD or plan – until July , 2001.

When Mrs. Murray requested copies of the CIGNA and GPA SPD's on March 7, 2001, she was referred by Crossmark's Human Resources department to a company website, but neither the SPD's nor the plans were posted there. Once the documents were posted (on August 2, 2001), employees could not print out copies, but could only view them online while at work. Non-employee beneficiaries had no access to the plan or SPD. The documents that were posted were buried in hundreds of layers of computer folders. These folders were not themselves accurate; should an employee have clicked on "Medical Plan," the employee would be informed "there are no items to show" in that file.

Mrs. Murray enrolled her husband, Hugh Murray, as a

---

[1] The Respondents have not produced separate SPD's and plans. They have claimed that, for all relevant plans, the plan is the SPD and the SPD is the plan.

dependent on her comprehensive major medical plan in Marcl 2000. On February 12, 2001, Hugh Murray, in the course c providing pest control, fell from the attic space in a singl family residence onto the concrete floor of the garage below He suffered severe closed head trauma, open head trauma an a broken left arm. He was comatose for five weeks, require further hospitalization for several weeks beyond the coma, an was eventually moved to a nursing facility. Hugh Murray ha had to undergo at least two surgical procedures to evacuate subdural hematoma. He was intubated, comatose, an ventilator dependent while in the hospital. He has require physical and cognitive rehabilitation and custodial care. Hi cognitive functioning remains drastically impaired. He ha been rendered blind. He can no longer speak. He require assistance with daily living functions and is not able to mak decisions or handle his financial affairs. His medical bills t date exceed $500,000.

Administrative Reasons for Denial

Mrs. Murray submitted claims to GPA for expenses incurred for Mr. Murray's treatment from February 12, 2001 until February 28, 2001. These claims were denied. Claims from March 1, 2001 were submitted to CIGNA. Some of the early claims were paid (approximately $90,000) but all subsequent claims were denied.

The GPA plan is over 70 pages long. The table of contents does not highlight or even list exclusions. Under this Plan (until February 28, 2001), Exclusion Three excludes:

> "Charges arising out of or in the course of any occupation for wage or profit, or for which the Covered Person is entitled to benefits under any Workers Compensation or Occupational Disease Law, or any such similar law."

Throughout the administrative period, and continuing well into the commencement of the lawsuit, Mrs. Murray was informed by Crossmark and GPA that benefits were being denied due to the "Workers Compensation" exclusion in the plan. [2] In communications with both Mrs. Murray and internally, the administrators claimed that the relied upon exclusion was a workers' compensation exclusion, and not a general work-related exclusion.

CIGNA, months after learning of Mr. Murray's extensive claims, drafted its plan, separated out the worker's compensation and work-related exclusions into two separate exclusions, and placed the work-related exclusion as the first-listed one. The CIGNA SPD/plan (from July, 2001) is also over 70 pages long. The table of contents does not have any listing for exclusions. Of 16 entries in the table of contents, all are in the same type and font and all are capitalized. Entry nine (9) of sixteen is "General Limitations" and refers readers to page 53. Unfortunately for a plan participant who wants to learn of the exclusions, page 53 covers vision benefits.

Despite having created a separate work-related exclusion, CIGNA informed Mrs. Murray that it was denying her claims under a worker's compensation exclusion. [3] Like GPA, CIGNA's internal communications indicate that it was denying claims on the basis of the worker's compensation exclusion and not the more general work-related exclusion.

---

[2]The references to the "plan" was to a plan that employees did not have physical copies of and that was not yet available on the website.

[3] Again, the reference to the plan was to a plan that employees had no access to and which did not actually exist until several months after the exclusions were claimed.

In response to inquiries regarding subrogation fro Crossmark, GPA and CIGNA, Mrs. Murray provided proof tha her husband was not covered under Texas workers compensation law. Neither was he required to be covered.

From Mrs. Murray's enrollment of Hugh Murray unde the Crossmark plan(s) in March, 2000 through the date of th Final Judgment in the District Court, Mrs. Murray pai premiums, and Crossmark accepted such payment, fo comprehensive major medical coverage for Mr. Murray unde Crossmark's plan. Nonetheless, Respondents indicated, i internal communications, that no administrator was to pay an benefits for Hugh Murray and instructed adjusters to deny al claims, in an apparent decision that all future health care need by Mr. Murray related back to his accident. Claims for Mr. Murray's gastrointestinal and cardiac problems were thus denied.

B. Basis for Jurisdiction and Proceedings Below

This is a case for wrongful denial of benefits under a self-funded employee welfare plan. Federal jurisdiction exists under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*

Despite Respondents' filing of multiple answers and amended answers, all of which stated numerous affirmative defenses, no Respondent claimed a plan exclusion as an affirmative defense. Moreover, no Respondent specified the reason for the denial of benefits, other than as "under the terms of the plan." In District Court, Plaintiff litigated the theory that benefit denial pursuant to the inapplicable Worker's Compensation exclusion was arbitrary and capricious.

Well into litigation, during certain questions at Mrs. Murray's deposition, Respondents first hinted that they were claiming a more general work-related exclusion. Not until the summary judgment pleadings did the Respondents finally settle on the theory that they had denied the claims under a work-related exclusion. The case was decided on cross-motions for summary judgment.

The parties settled Petitioners' claims under ERISA for statutory damages for failure to provide a summary plan description to Mrs. Murray. The District Court, on July 22, 2004, found that Respondent's had not waived the affirmative defense of the particular exclusion by not pleading it, reasoning that Petitioners were not surprised or prejudiced. The District Court denied Petitioners' motion for partial summary judgment on liability, and granted Respondents summary judgment that the denial of benefits was not an abuse of discretion. Final judgment in the case, based mostly on the July 22, 2004 order, was entered October 4, 2004, ordering Plaintiff take nothing (dismissed claim for settled statutory damages notwithstanding).

On timely appeal, the Fifth Circuit affirmed the judgment, per curiam, on January 23, 2006, holding that Respondents' pleading of claim denial "in accordance with the terms and conditions of the plan" was sufficient to satisfy both ERISA and FRCP Rule 8.

REASONS FOR GRANTING THE PETITION

A. Summary of the Argument

As Justice Ginsburg has noted, it is time to recogniz "the rising judicial chorus urging that Congress and [this] Cou revisit what is an unjust and increasingly tangled ERIS/ regime." *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 222, 12 S.Ct. 2488, 2503 (2004) (Ginsburg, J., *concurring*) (quotin *DiFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 453 (3rd Ci 2003) (Becker, J., concurring)). Justice Ginsburg continue that, "[b]ecause the Court has coupled an encompassin interpretation of ERISA's preemptive force with a crampe construction of the 'equitable relief' allowable under § 502(a)(3), a 'regulatory vacuum' exists: '[V]irtually all stat law remedies are preempted but very few federal substitutes ar provided.'" *Aetna v. Davila* at 200 (quoting *DiFelice v. Aetna* at 456).

The consequences of the "unjust and tangled" ERISA regime are legion. In addition to the lack of equitable relief available and the preemption of state fair claims, insurance, or trade practice law, ERISA claimants may not find refuge in state constitutional provisions. *See Wood v. Prudential Ins. Co. of America*, 207 F.3d 674 (3rd Cir. 2000). Since ERISA precludes statutory penalties, ERISA administrators have an incentive to deny all claims and force claimants to enter court. Once an ERISA claimant goes to federal court to obtain wrongfully denied ERISA benefits, the court itself is constrained in reviewing that benefit determination. In all but the rare case, lower federal courts, in following this Court's decision in *Firestone Tire and Rubber v. Bruch*, 489 U.S. 101, 110, 109 S.Ct. 948, 954 (1989), must defer to the administrators' decision. This deference is given, no matter the

adminitrator's decision is barely reasonable. *See Vega v. Nat'l Life Ins. Services*, 188 F.3d 287, 297 (5th Cir. 1999) (*en banc*). Moreover, this deference is given the administrator even if the administrator itself has grossly flouted ERISA's procedural safeguards for employee/beneficiaries. *See Kreutzer v. A.O. Smith Corp.*, 951 F.2d 739, 744 (7th Cir. 1991) (no substantive rights due to administrator's procedural violations).

When Administrators, like Respondents, have failed to comply with the most basic procedural safeguard afforded plan participants under ERISA – providing a copy of the plan and/or SPD governing claims to participants and beneficiaries (*See* 29 U.S.C. §§ 1022, 1024(b); 29 C.F.R. §§ 2520.104b-1, 2520.104b-3, 2520.107-1(b)(3); *See also* 29 C.F.R. §§ 2560.503-1(b)(5); 2560.503-1(g)) – the Court must ensure that those Administrators may not then use this to their tactical advantage. It is inapropriate for courts, via discretionary review, to enforce an Administrator's strict interpretation of a plan that did not exist, was applied post-hoc, or was never provided to participants. Congress never, in its stated purposes for ERISA, intended to create a category of judicial rubber stamping, let alone judicial complicity in enforcing plan terms not meeting ERISA standards.

The adoption of *de novo* judicial review addresses this problem. The doctrine of Reasonable Expectations provides an additional or alternative safeguard.

B. The Abuse of Discretion standard has proven untenable

ERISA requires that employee welfare plans be governed by a written instrument that is "sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." 29

U.S.C. § 1022(a)(1). For the period from March 1, 2001 to July 2001, no plan documents existed to guide CIGNA' administration of medical claims in this case. This Court ha never explicitly decided the important question of whether backdated or post-hoc instrument may exclude claims fo benefits under an ERISA welfare plan, as Respondents hav done here. Thus, this Court has also never decided whether th abuse of discretion review is appropriate under thes circumstances.

The District Court in this case explicitly held that a failure to provide an SPD does not give rise to substantive rights and the Fifth Circuit affirmed that decision for essentially the reasons stated below. (App.) Other Circuits indicate a reluctance to allow such "informal" mechanisms as unwritten or retrospective amendments to govern claims. *See, e.g., Frommert v. Conkright*, 433 F.3d 254, (2nd Cir. 2006) (an ERISA plan "amendment" occurs not when administrator changes plan, but "when employees are properly *informed* of a change".(emphasis in original)); *Burke v. Kodak Retirement Income Plan*, 336 F.3d 103, 110 (2nd Cir. 2003) (directing entry of judgment for beneficiary prejudiced by deficient SPD); *Confer v. Custom Engineering Co.*, 952 F.2d 41, 43 (3rd Cir. 1991) (informal amendments may not govern benefit determinations and amendments may "operate only prospectively"); *cf. Garst v. Wal-Mart Stores, Inc.*, 30 Fed. Appx. 585, 590 (6th Cir. 2002) (unpublished); *Hightshue v. AIG Life Ins. Co.*, 135 F.3d 1144, 1149 (7th Cir. 1998) (no sustantive remedy).

The issue of the non-existent SPD may be equally well stated as a procedural one. That is, Petitioners are not only claiming a right to recover simply because there was no SPD, but because Respondents may not themselves rely on exclusions that are nowhere mentioned. *Accord Horn v.*

Cendant Operations, Inc., 69 Fed. Appx. 421, 428 (10th Cir. 2003) ("Employees cannot be bound to policy terms for which they received no notice") (unrepoted); *See also Heinglein v. Informal Plan for Plant Shutdown Benefits*, 974 F.2d 391, 400 (3rd Cir. 1992) (in the absense of formal plan documents, courts should consider other documents); *Clark v. Metropolitan Life Ins. Co.*, 67 F.3d 299, WL 592102 at *1 (6th Cir. 1995) (unpublished) ("A plan administrator attempting to establish an exclusion from coverage has the burden to establish by a preponderance of the evidence that a covered employee's illness or medical condition is excludable."); *Donovan v. Dillignham*, 688 F.2d 1367, 1372 (11th Cir. 1982) (although ERISA requires a written instrument, such instrument is not a prerequisite to coverage).

Even when courts have not found that the failure to comply with ERISA SPD regulations gives rise to a substantive right, those same courts have noted that such failure by an administrator may give rise to certain procedural rights. *See, e.g., Burke* at 110 (failed notice and SPD's may allow a *de novo* standard rather than a deferential one). The adoption of a *de novo* standard of judicial review should be the rule in these cases. *Accord Firestone* at 956-957 (review is to be *de novo* unless **the plan** confers discretion). In the absence of a procedurally correct plan conferring discretion, the *de novo* standard is consistent with this Court's reasoning in *Firestone v. Bruch*.

In this case, the post-hoc application of plan documents and exclusions therein to Petitioners' claims is the very definition of arbitrary and capricious. Yet, the courts below did not consider this in their arbitrary and capricious/abuse of discretion analysis. *Cf. Jebian v. Hewlett-Packard Co.*

Employee Benefits Organization Inc. Protection Plan, 349 F.3 1098, 1105 (9th Cir. 2003).

ERISA's purpose is to promote "the interests c employees and their beneficiaries in employee benefit plans through protection of benefits. *Firestone Tire & Rubber v Bruch*, 489 U.S, 101, 113, 109 S.Ct. 948 (1989). To ensur these ends, regulations require that plans provide notice i writing of "the specific reasons for such denial, written in manner calculated to be understood by the participant" whe denying benefits. 29 U.S.C. § 1131.

The Fifth Circuit, below, determined that this "specific reasons" for denial requirement was satisfied by Respondents by their general reference to "plan terms." This directly conflicts with the statutory scheme, and with other circuits. *See VanderKlok v. Provident Life and Accident Ins. Co.*, 956 F.2d 610 (6th Cir. 1992) (failure to reference specific plan provision is inadequate notice); *Clark v. Metropolitan Life Ins. Co.* at *3-4; *Brumm v. Bert Bell NFL Retirement Plan* , 995 F.2d 1433, 1436 (8th Cir. 1993) (denial because "did not meet plan requirements" is "inadequate"). *See also* 29 U.S.C. §1133; 29 C.F.R. § 2560.503-1(g) (ERISA notice particulars). Moreover, this vague denial prejudiced Petitioners in litigation as they defended against the exclusion claimed at administrative level by Crossmark, GPA and CIGNA (Workers Comp) and did not prepare for so as to adequately defend against other exclusion(s) and/or interpretation(s) later claimed by Administrators. Moreover, they did not develop alternative arguments against those new exclusions: that GPA's exclusion is not subjunctive but workers comp only; that CIGNA's exclusion doesn't apply because of an inherent ambiguity in the plan between work-place exclusions and pre-existing condition allowable claims.

Despite the courts below finding that Petitioners were not harmed by the failure of notice under ERISA or Fed. R. Civ. Proc. Rule 8, this decision, too, was influenced by the abuse of discretion review. Essentially, the courts were constrained to defer to the administrators' relative freedom in interpreting their plans so as to justify claim denial, whether in compliance with civil procedure or not and whether in compliance with ERISA notice or not. The adoption of a *de novo* standard of judicial review is especially necessary in those cases where, as here, the Administrator's procedural violations result in substantive harm to the benefit claimant. It would ensure that such administrator abuses did not go unchecked. It would also ensure that such abuses are not rubber stamped by courts claiming tied hands.

C. The Fifth Circuit's rejection (by affirmation) of the Reasonable Expectation Doctrine presents a conflict between the circuits on this important question of federal common law under ERISA

In *Firestone Tire and Rubber v. Bruch*, this Court held that "courts are to develop a 'federal common law of rights and obligations under ERISA-regulated plans'" *Firestone*, 489 U.S. 101, 110, 109 S.Ct. 948, 954 (1989) (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56, 107 S.Ct. 1549, 1558 (1987)). One such area of federal common law regulating rights and obligations under ERISA is the "Reasonable Expectations" doctrine.

Under Reasonable Expectations, an Administrator waives reliance on (1) plan language that is ambiguous, as it will be construed against the drafter and in accordance with the reasonable expectations of the insured (*See Gallagher v.*

Reliance Std. Life Ins. Co., 305 F.3d 264, 269 (4th Cir. 2002); (2) plan exclusions that are not clear and conspicuous (*Se Saltarelli v. Bob Baker Group Medical Trust*, 35 F.3d 382, 38 (9th Cir. 1994)); and (3) plan or claims administration tha interferes with a beneficiary's reasonable expectation o coverage (*See Ruttenberg v. United States Life Ins. Co.* , 41 F.3d 652, 668 (7th Cir. 2005)). As to the third element, a administrator may not accept premium payments whil constructively terminating benefits. *See Tester v. Reliance Standard Life Ins. Co.*, 228 F.3d 372, 377 (4th Cir. 2000).

Although rejected in the case below, the Reasonable Expectations Doctrine has been accepted in numerous circuits, including the Second Circuit (*Lifson v. INA Life Ins. Co. Of New York*, 333 F.3d 349, 353 (2nd Cir. 2003)); Third Circuit (*Heinglein v. Informal Plan for Plant Shutdown Benefits* at 401 (3rd Cir. 1992); *Gallagher* at 269 (4th Cir. 2002)); Fourth Circuit (*Wheeler v. Dynamic Engineering, Inc.*, 62 F.3d 634, 638 (4th Cir. 1995)); and Ninth Circuit (*McClure v. Life Ins. Co. Of N. Am.*, 84 F.3d 1129, 1135 (9th Cir. 1996); *Estate of Shockley v. Alyeska Pipeline Service Co.*, 130 F.3d 403 (9th Cir. 1997) (limiting the doctrine to welfare-benefit ERISA plans, and not pension plans under ERISA)).

In addition to the Fifth Circuit's refusal to consider the Reasonable Expectations Doctrine in ERISA in this case, the Tenth Circuit has held the doctrine inapplicable to ERISA. *See Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1101 (10th Cir. 1999).

The Seventh Circuit has never expressly decided the question. In *Hightshue v. AIG Life* at 1150 (7th Cir. 1998), the Seventh Circuit noted in dicta that reasonable expectations may not be applicable to ERISA. In a later decision, the Seventh Circuit seemingly approved of the doctrine, but decided the

case on other grounds. *See Ruttenberg v. United States Life Ins. Co.*, 413 F.3d 652, 668 fn. 19 (7th Cir. 2005).

The lead case among the circuits on the contours of the Reasonable Expectations Doctrine is *Saltarelli v. Bob Baker Group Medical Trust*, 35 F.3d 382 (9th Cir. 1994). In *Saltarelli*, the Ninth Circuit found justification for the doctrine in furthering the statutory purposes and disclosure requirements of ERISA. *Id.* at 386-87. That is, that holding ERISA-governed insurance plans to the Reasonable Expectations standard of interpreting the plan documents is consistent with, and furthers, ERISA statements that disclosure of plan terms is to made "in the interests of employees and their beneficiaries." *Saltarelli* at 386-87 (citing 29 U.S.C. § 1001). Moreover, the Ninth Circuit found support for the doctrine in the insurance laws of (at the time) "at least thirty states" and the *contra proferentum* doctrine applied in ERISA cases in the Fifth and Eighth Circuits. *Saltarelli* at 386-87.

Under the Reasonable Expectations doctrine in this case, the inconspicuous, buried and mislabled exclusions in the GPA and CIGNA plans require the Court to order benefit payment in accordance with Petitioners' reasonable expectation of coverage. Moreover, the ambiguity in the GPA plan exclusion as to whether it applies to worker's compensation coverable injuries or all work-related injuries would be construed in accordance with Petitioners' expectations of coverage. Additionally, the ambiguity as to whether Petitioner is covered under allowed pre-existing conditions or excluded under a competing work-related exclusion under the CIGNA policy would be construed in Petitioners' favor. Finally, CIGNA's constructive termination of Petitioners' benefits would not meet Petitioners' reasonable expectation of coverage.

CONCLUSION

The facts of the case below typify the "unjust an tangled" ERISA regime Justice Ginsburg referred to in *Aetn v. Davila*. The Administrators flouted ERISA's disclosur provisions, providing no copies of the ERISA plans or SPDs t employees and beneficiaries. The Administrators changed th plan to specifically exclude Mr. Murray. The Administrator buried plan exclusions within the plan. The Administrator continued to accept premium payments while ordering claim adjusters to deny all claims. The Administrators denied claim on the basis of one exclusion (or interpretation of it) at the Administrative phase and switched to a new exclusion (interpretation) in the middle of litigation.

And to this, the Courts have deferred to the Administrators' discretion. The Courts have found that Petitioners have no recourse to state fair insurance practice law. The Courts found no substantive recourse under ERISA for these gross procedural abuses, except for the woefully inadequate $100 a day fine set in the 1970's for disclosure violations. The Courts found that an unjust, abusive and, by definition, arbitrary ERISA administrator is still free to deny claims under these circumstances at its discretion, outside the constraints of state contract and insurance law.

This Court should grant the Petition for Certiorari in order to resolve the split in the circuits regarding the applicability of the Reasonable Expectations Doctrine to ERISA welfare-plan benefit claims cases. This doctrine needs to become part of the federal common law governing ERISA so as to check unjust and abusive ERISA practices. Court review of administrator's claim practices and plan interpretation according to this doctrine would help fulfill ERISA's purpose of providing benefits to employees.

This Court should grant the Petition for Certiorari in order to reconsider the standard of review in cases involving an ERISA administrator giving itself discretion. Requiring a *de novo* review in all ERISA welfare-benefit plan cases would check unjust and abusive ERISA practices. Certainly, *de novo* review would be an appropriate standard on a showing of an Administrator's procedural violations. *De novo* review of ERISA claims would untangle at least one of ERISA's injustices – the perverse disincentive ERISA administrator's now have to pay valid claims. The correction of this disincentive is necessary to effectuate ERISA's statutory purposes. *See* 29 U.S.C. §§ 1001(a); 1001b(c).

The petition for writ of certiorari should be granted.

Respectfully Submitted,

EDWARD L. PINA*
**Counsel of Record*
Edward L. Pina & Associates, P.C.
8118 Datapoint Drive
San Antonio, TX 78229
(210) 614-6400

DANIEL Y. KRUGER
Daniel Y. Kruger, P.C.
TERESA K. VALENTIC
JESSICA SELINKOFF
The Ariel House
8118 Datapoint Drive
San Antonio, TX 78229
(210) 614-6400

Counsel for Petitioners

United States Court of Appea
Fifth Circuit
FILED
January 23, 2006
Charles R. Fulbruge III
Clerk

UNITED STATES COURT OF APPEALS
For the Fifth Circuit

No. 04-51253

NEVA MURRAY, Individually and as Guardian of Hugh Murray, Ward

Plaintiff-Appellant,

VERSUS

CROSSMARK SALES, INC.; CONNECTICUT GENERAL LIFE INSURANCE COMPANY; ET AL.,

Defendants-Appellees.

Appeal from the United States District Court
For the Western District of Texas

(5:03-CV-85)

Before HIGGINBOTHAM, DeMOSS, and OWEN Circuit Judges.

PER CURIAM:[****]

Plaintiff-Appellant Neva Murray appeals the distric court's affirmance of the denial of her benefits claim on th basis of an ERISA-plan exclusion. We AFFIRM.

Defendant-Appellee Crossmark Sales, Inc ("Crossmark") employs Murray. Since 1996, Murray ha participated in Crossmark's Medical Plan, a self-funded pla providing medical, prescription drug, and vision benefits t plan participants under the terms of both the Plan Documen and the Summary Plan Description (the "SPD").[5] Upon joinin the Plan, Murray signed an enrollment application, agreeing t be bound by the terms and conditions of the Plan Document an the SPD.

As Plan administrator, Crossmark delegated clain administration to a third party claims administrator, which wa empowered to make benefit determinations. Over the course o Murray's participation in the Plan, at least two claim administrators were named by Crossmark. In 1997, Defendant-Appellee Group & Pension Administrators, Inc. ("GPA") became the claims administrator. Then, on March 29, 2000 Murray enrolled her husband, Mr. Hugh Murray, as a dependent beneficiary in the Plan. Mr. Murray was self-employed as a pest control contractor at that time. On March 1, 2001, Crossmark replaced GPA with Defendant-Appellee Connecticut General Life Insurance Company ("CIGNA") as claims administrator. Thus, effective March 1, 2001, CIGNA exercised its discretion to make benefit determinations under the Plan for claims occurring on or after March 1, 2001.

[****]Pursuant to 5TH CIR. R. 47.5, the Court has determined that this opinion should not be published and is not precedent except under the limited circumstances set forth in 5TH CIR. R. 47.5.4.

[5]All parties conceded before the district court that the Plan is an employee benefit plan under the Employee Retirement Income and Security Act ("ERISA"), 29 U.S.C. § 1002 *et seq*.

On February 12, 2001, Mr. Murray suffered serious injury when he fell from an attic onto a concrete floor while performing pest control work for profit at his customer's residence. Mr. Murray's medical bills exceed $500,000. Murray submitted claims to GPA for expenses incurred for his treatment through February 28, 2001. During investigation into the claim, Murray averred that her husband's injuries were work related. GPA sent a denial of benefits notice to Murray, indicating that Mr. Murray's injuries were not covered because of an exclusion of coverage for any work-related injury.[6] Crossmark also instituted its own investigation and likewise concluded that Mr. Murray's injuries were expressly excluded under the Plan's terms. When CIGNA replaced GPA as the claims administrator, the Plan was amended, and Crossmark gave its employees notice of the material amendments as

---

[6]The SPD, under GPA's administration, provided,

> The following exclusions and limitations apply to expenses incurred by all Covered Persons:
>
> . . .
>
> 3. Charges arising out of or in the course of any occupation for wage or profit, or for which the Covered Person is entitled to benefits under any Worker's Compensation or Occupational Disease Law, or any such similar law.

The SPD, under CIGNA's administration, provided,

> No payment will be made for expenses incurred for you or any one of your Dependents:
> • for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;
> • for or in connection with a Sickness which is covered under any workers' compensation or similar law.

required by ERISA, 29 U.S.C. § 1024(b)(1) ("The administrat shall furnish to each participant, and each beneficiary receivin benefits under the plan, a copy of the summary pla description, and all modifications and changes referred to in [2 U.S.C. § 1022(a)] . . . .").

Because of the change in the entity administratin claims, Murray submitted claims for expenses incurred afte March 1, 2001 to CIGNA. Unlike GPA, CIGNA uses a syster of claims administration called "pay and chase." Consisten with this system, CIGNA initially paid Murray based upon th claims received and then instituted an investigation. CIGN/ paid approximately $90,000 in benefits but, after investigation determined that Mr. Murray's claims were barred by the work related exclusion. Murray contested the denials, and, in its rol as claims administrator at the time, CIGNA affirmed th decision to deny Mr. Murray's claims for benefits.

Murray filed this lawsuit against Crossmark, GPA, an CIGNA (collectively, "Defendants"), arguing that the denial o benefits was arbitrary and capricious, resulting in an abuse o discretion. The Defendants filed a motion for summary judgment, arguing that Murray's claims were barred by the exclusions and limitations included in the SPD. Murray filed a motion for partial summary judgment on February 27, 2004. On July 22, 2004, the district court denied Murray's motion for partial summary judgment, granted judgment for GPA and CIGNA, and granted in part judgment for Crossmark as to the denial of benefits of claim. By stipulation, the parties dismissed with prejudice Murray's remaining claim against Crossmark. Murray timely appealed the district court's grant of judgment on October 4, 2004 to Defendants.

This Court reviews *de novo* the district court's grant of summary judgment, applying the same standards as the district court. *Young v. Equifax Credit Info. Servs., Inc.*, 294 F.3d 631, 635 (5th Cir. 2002); *see also* FED. R. CIV. P. 56(c). When the plan administrator enjoys authority to make a final

determination of eligibility for claim benefits, as here, we review the plan administrator's denial of benefits for an abuse of discretion. *See Duhon v. Texaco, Inc.*, 15 F.3d 1302, 1305 (5th Cir. 1994); *see also Gosselink v. AT&T, Inc.*, 272 F.3d 722, 726 (5th Cir. 2001).

Murray argues that the district court erred in denying her benefits claim on the basis of an affirmative defense – the work-related exclusion – that Defendants failed to plead. The district court assumed for purposes of analysis, without deciding, that an ERISA-plan exclusion must be pled as an affirmative defense under Federal Rule of Civil Procedure 8(c). The district court then determined that Defendants did not waive the defense provided by the work-related exclusion in failing to plead it. Rule 8(c)'s provision that waiver results from a failure to plead is not absolute because "[w]here the matter is raised in the trial court in a manner that does not result in unfair surprise, . . . technical failure to comply precisely with Rule 8(c) is not fatal." *Allied Chem. Corp. v. Mackay*, 695 F.2d 854, 855-56 (5th Cir. 1983); *Jones v. Miles*, 656 F.2d 103, 107 n.7 (5th Cir. 1981); *see also Bull's Corner Rest., Inc. v. Dir., Fed. Emergency Mgmt. Agency*, 759 F.2d 500, 502 (5th Cir. 1985), *superceded in part by rule on other grounds*, FED. R. CIV. P. 52(a).

We find the work-related exclusions here unambiguous, and the record reflects that Murray was on notice of the work-related exclusion in the SPDs prior to the filing of the lawsuit. Murray concedes that the Defendants asserted the work-related exclusion in their June 11, 2003 Motion to Limit Discovery, filed over eleven months before the trial setting. Furthermore, Defendants affirmatively pled in their answer to Murray's Second Amended Complaint that the claims were denied "in accordance with the terms and conditions of the Plan." Based on this record, the district court did not err in concluding that the work-related exclusion defense was not waived, nor did the court err in concluding that the denial of benefits under the

unambiguous terms of the work-related exclusions was neithe arbitrary nor capricious.

After thorough review of the briefs, the oral argument of the parties, and relevant portions of the record, we AFFIRM the district court's judgment for Defendants on Murray's denia of benefits claim essentially for the well-stated reason provided by the district court.

AFFIRMED.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

NEVA MURRAY, INDIVIDUALLY, AND AS GUARDIAN OF HUGH MURRAY, WARD Plaintiffs,	§	
v.	§	NO. SA.03 -CA-0085-XR
CROSSMARK SALES, INC.; CONNECTICUT GENERAL LIFE INSURANCE COMPANY A/K/A CIGNA HEALTHCARE; and GROUP&PENSION ADMINISTRATORS, INC. Defendants.	§	

FINAL JUDGMENT

On July 22, 2004, the Court granted the Motions for Summary Judgment filed by the Defendants, CROSSMARK, Inc. (improperly named "CROSSMARK Sales, Inc."), Group & Pension Administrators, Inc., and Connecticut General Life Insurance Company a/k/a CIGNA HealthCare and dismissed with prejudice Plaintiffs', Neva Murray, Individually, and as Guardian of Hugh Murray, Ward, claims for a declaratory judgment and wrongful denial of benefits under 29 U.S.C. § 1132(a)(1)(B) contained in the Plaintiffs' Second Amended Complaint. In the summary judgment Order, the Court allowed Plaintiffs to amend their complaint to assert a claim for statutory penalties under 29 U.S.C. § 1132(c) against

CROSSMARK, Inc. On or about July 30, 2004, Plaintiffs file a Third Amended Complaint that asserted five addition: Counts against CROSSMARK, Inc. and filed a Motion fc Leave to File Count Five in that Third Amended Complaint. O August 30, 2004, the Court issued an Order that denie Plaintiffs' Motion for Leave to add Count Five and dismisse Counts One and Two, leaving only Counts Three and Four i the Third Amended Complaint. The parties have informed th Court that they have resolved Plaintiffs' claims for penaltie under 29 U.S.C. § 1132(c) in the Third Amended Complain and have presented the Court with their Agreed Dismissa Order.

It appearing to the Court that all claims in this matte have been disposed of, it is therefore ORDERED ADJUDGED, and DECREED, that Plaintiffs, Neva Murray Individually and as Guardian of Hugh Murray, Ward, take nothing on any of their claims against Defendants asserted ir this lawsuit. Costs to be borne by the party incurring same.
DATED: October 4, 2004

XAVIER RODRIGUEZ
United States District Judge

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

NEVA MURRAY, et al.	)	
Plaintiffs,	)	
VS.	)	Civil Action No:
	)	SA-03-CA-85-XR
CROSSMARK SALES,	)	
INC., et al.	)	
Defendants.	)	

.ORDER

On this date, the Court considered Defendants Crossmark, Inc. ("Crossmark") and Group & Pension Administrators, Inc.'s ("GPA") joint motion for summary judgment (docket no. 52), which was joined by Defendant Connecticut General Life Insurance Company ("CGLIC") and the responses. The Court also considered Plaintiffs' motion for partial summary judgment (docket no. 54) and the responses. Because the Plan Administrator's decision to deny benefits under the work-injury exclusion was not arbitrary and capricious, Plaintiffs are not entitled to recover benefits under the plan. However, because a fact issue exists as to whether Crossmark adequately provided a Summary Plan Description to Plaintiffs, Plaintiffs may amend their complaint to assert a claim for statutory administrative penalties. Thus, Defendants' Motion for Summary Judgment is GRANTED in part, and DENIED in part (docket no 52). Plaintiffs' Motion is DENIED (docket no. 54).

I.

Facts and Procedural Background

Hugh Murray was self-employed as a pest contr exterminator, and during the course of his employment, fe from an attic on February 12, 2001. The fall left him comatos for five weeks and hospitalized for an extended perio Subsequently, he was moved to a nursing facility. His wife an guardian, Neva, brought this suit seeking a declaration o whether the medical plan offered by her employer, Crossmark and administered by GPA and later CGLIC,[1] is an "employe benefit plan" under the Employee Retirement Income an Security Act ("ERISA"), 29 U.S.C. §§ 1002, *et seq.* All parties however, now concede that the plan is an ERISA plan. Thus her remaining claim argues that Defendants' decision to den benefits was arbitrary and capricious resulting in an abuse o discretion. She seeks to recover benefits under the plan, an attorney's fees incurred in bringing this suit.

II.

Summary Judgment Standard

A summary judgment movant must show by affidavit o other evidence that there is no genuine issue regarding an material fact. *Celotex Corp. v. Catrett, 477* U.S. 317, 32 (1986). To establish that there is no genuine issue as to an material fact, the movant must either submit evidence tha negates the existence of some material element of the nonmoving party's claim or defense, or, if the crucial issue is one for which the nonmoving party will bear the burden o

---

[1]On March 1, 2001, CGLIC (also known as CIGNA) replaced GPA as the claims administrator.

proof at trial, merely point out that the evidence in the record is insufficient to support an essential element of the nonmovant's claim or defense. *Lavespere v. Niagra Machine & Tool Works, Inc.*, 910 F.2d 167, 178 (5th Cir. 1990), *cert. denied*, 510 U.S. 859 (1993). Once the movant carries its initial burden, the burden shifts to the nonmovant to show that summary judgment is inappropriate. *See Fields v. City of South Houston*, 922 F.2d 1183, 1187 (5th Cir. 1991).

Summary judgment is required if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law. F ED. R. CIV. P. 56(c); *Celotex Corp.*, 477 U.S. at 322. In order for a court to conclude that there are no genuine issues of material fact, the court must be satisfied that no reasonable trier of fact could have found for the nonmovant, or, in other words, that the evidence favoring the nonmovant is insufficient to enable a reasonable jury to return a verdict for the nonmovant *See Anderson v Liberty Lobby, Inc*, 477 U.S. 242, 250 n.4 (1986). In making this determination, the court should review all the evidence in the record, giving credence to the evidence favoring the nonmovant as well as the "evidence supporting the moving party that is uncontradicted and unimpeached, at least to the extent that evidence comes from disinterested witnesses" and disregarding the evidence favorable to the nonmovant that the jury is not required to believe. *Reeves v. Sanderson Plumbing Prods., Inc.*, 530 U.S. 133, 152 (2000).

III.

Analysis

A. ERISA Generally

ERISA authorizes federal court review of a pla administrator's denial of a claimant's claim. 29 U.S.C. 1132(a)(1)(B). Factual determinations made by an administrat under an ERISA plan are reviewed for an abuse of discretio *Pierre v. Conn. Gen. Life Ins. Co.,* 932 F.2d 1552,1562 (5t Cir.), *cert. denied,* 502 U.S. 973 (1991). So long as the ERIS benefit plan provides the plan administrator with discretionar authority to construe the terms of the plan, the pla administrator's denial of benefits is also reviewed for an abus of discretion. *Gosselink v. AT&T, Inc.,* 272 F.3d 722,726 (5' Cir. 2001). When a court applies the abuse of discretio standard, it analyzes whether the plan administrator acte arbitrarily or capriciously. *Lain v. UNUM Life Ins. Co. of Am.* 279 F.3d 337, 342 (5th Cir. 2002). Thus, "[a]n administrator' decision to deny benefits must be 'based on evidence, even i disputable, that clearly supports the basis for its denial. " *Id citing Vega v. Nat'l Life lns. Servs. Inc.,* 188F.3d 287, 299 (5' Cir. 1999).

B. The Crossmark Plan

The plan administrator denied Plaintiffs' claim fo medical benefits based on an exclusion for on the job injuries. The Crossmark Major Medical Plan, effective January 1 , 1997, and restated January 1, 1999, contained the following exclusion under Major Medical Plan Exclusions and

Limitations:

3. Charges arising out of or in the course of any occupation for wage or profit, or for which the Covered Person is entitled to benefits under any Worker's Compensation or Occupational Disease

Law, or any such similar law.

With the change of administrators in March of 2001, the Plan was modified and the language was changed to read:

> No payment will be made for expenses incurred for you or any one of your Dependents for or in connection with an injury arising out of, or in the course of, any employment for wage or profit.

Plaintiffs do not contest that Mr. Murray was injured during the course and scope of his selfemployed extermination business. Further, other than the issues raised below, Plaintiffs do not dispute that the plan administrator had discretionary authority to construe the plan or that the administrator's decision was not arbitrary or capricious.

C. Plaintiff argues the work-related exclusion is an affirmative defense that was not pled and has been waived.

Plaintiffs argue that Defendants have not pled the above exclusion as an affirmative defense, and as such, the affirmative defense has been waived. Assuming without deciding that exclusions in an ERISA plan are affirmative defenses subject to Federal Rule of Civil Procedure 8(c), Defendants' failure to plead the exclusion did not result in waiver because Plaintiffs cannot argue they were prejudiced. Although it is well established that a failure to plead an affirmative defense "generally results in a waiver," the rule is not without exception. *Allied Chem. Corp. v. Mackay*, 695 F.2d 854, 855-56

(5th Cir. 1983). When a "matter is raised . . . in a manner tha does not result in unfair surprise, . . . technical failure to compl precisely with [Rule 8(c)] is not fatal." *Id.* Plaintiffs have bee aware that Defendants relied upon the work-related exclusio since 2001, years prior to this lawsuit ever being filed. Furthe the work-related exclusion was referenced throughout th discovery process and the dispositive motions. *See Allian Versicherungs, AG v. Profreight Brokers Inc.,* 99 Fed. Appx 10, 12 (5th Cir. 2004). Given that the Plaintiffs have not bee surprised or prejudiced by Defendants' failure to state th exclusion specifically in its answer, the defense has not bee waived.

D. Plaintiffs urge the Court to adopt the doctrine o reasonable expectations.

Alternatively, Plaintiffs argue that the doctrine o reasonable expectations requires that an exclusion be conspicuous, plain and clear in order to be enforceable. "Unde the 'reasonable expectations' doctrine, as a matter of federal common law governing ERISA contracts, even an unambiguous exclusion maybe unenforceable unless it is sufficiently 'clear, plain, and conspicuous' to overcome a layperson's reasonable expectations." *Saltareii v. Bob Baker Group Med. Trust,* 35 F.3d 382, 385-87 (9th Cir. 1 994). Neva Murray states that she was given Crossmark's "Benefits with Choice, Enrollment Guide and Benefits Summary" to review in order to decide whether she would enroll herself and her family in the medical plan. She argues that she was not given a copy of the SPD, and that in the materials given to her at the time of her enrollment, there was no reference to a work-related injury exclusion. Additionally, Plaintiffs argue that because GPA initially made medical benefit payments on behalf of Mr. Murray that they had a reasonable expectation of benefits under the policy.

However, because the Fifth Circuit has not specifically adopted the doctrine of reasonable expectations in the ERISA context, and *Saltarelli* relied in part upon California state law for its holding, this Court refuses to adopt this doctrine.

Defendants argue that even if the Court did accept the doctrine of reasonable expectation, Plaintiffs were made aware of the exceptions and technical support was made available to them if they had any questions. Defendants state that Neva Murray was continually enrolled in Crossmark's Medical Plan since 1996, and that the Plan created a work-related exclusion in 1997. At the time of her enrollment, Defendants argue that the Summary Plan Description ("SPD") "was available to all participants through Crossmark's Human Resources Department." They further argue that in 1999, Crossmark posted the SPD on public folders in its computer system, which could be accessed by all employees. Accordingly, Defendants argue that when Neva Murray enrolled her husband in the Medical Plan on March 29, 2000, a SPD existed that contained the work-related exclusion, a copy of the SPD was made available to her through the public folders of Crossmark's computer system, and she was aware that GPA was the Plan Administrator and could have called them or Crossmark's human resources department with any questions regarding coverage.

As stated above, Crossmark's ERISA Plan became effective in 1997, and the Plan was restated on January 1, 1999. The Plan Document and SPD was 71 pages in length. *See* Exhibit A-S of Defendants' Motion for Summary Judgment and Brief in Support (docket no. 52). The Table of Contents contained a category titled Major Medical Plan Exclusions and Limitations (pages 27-29). The work-related exclusion is found on page 27 and is listed as exclusion number 3 of 53. On April 11, 2000, after Neva Murray enrolled her husband in the medical plan but before his injury, Crossmark employees were

notified that GPA had a web site to assist with customer servic issues. On January 1 5, 2001, Crossmark notified its employe that a new benefits plan was being instituted effective March 2001. Employees were provided an enrollment guide an directed to contact the Benefits Department with any questior they may have. Thus, even if the Court adopted the doctrine c reasonable expectations, the exclusion was plain, clear, an sufficiently conspicuous. In this case the SPD is unambiguou regarding the work-related exclusion. Although any failure b Defendants to adequately provide Plaintiffs with a SPD ma trigger liability under ERISA's notice and provision sectior *(see infra* relating to 29 U.S.C. § 1132(c)(1)), any such failur does not affect their substantive rights under the Plan, or th decision of the plan administrator.[2]

This case is similar to *Scott v. Poly-Tech, Inc.,* 1999 W. 33120743 (N.D. Miss. 1999), *aff'd,* 234 F. 3d 706 (5th Ci 2000). In *Scott,* the plaintiff was denied benefits based on a pre existing medical condition provision. Scott argued that the Pla Administrator could not deny her coverage based on th exclusion because she was not provided with a copy of th SPD. The plaintiff further argued that agents of the Pla Administrator made oral representations to her that she woul be entitled to full medical coverage. Scott could not argue tha the Plan Administrator's decision was arbitrary or capricious accordingly she argued that the Plan should be estopped fror denying coverage because of the failure to provide a SPD. I

---

[2]Plaintiffs cannot offer evidence that the plan administrator's decision was the product of an arbitrary decision or the plan administrator's whim. Plaintiffs are unable to overcome the fact that Mr. Murray was injured during the course of his employment, and the Plan clearly excluded such an injury from coverage. *See Tillery v. Hoffman Enclosures, Inc.,* 280 F.3d 1192, 1198 (8th Cir. 2002) ("The Tillerys also question whether they ever received a copy of the SPD. Assuming they did not, they fail to explain how such an oversight affected their substantive rights or the decision of the plan administrator.").

reviewing the statute and cases the Court in *Scott* concluded that there was "nothing within the statutory provision suggesting that a plan beneficiary should receive a benefit award based on a plan administrator's failure to disclose required information." The *Scott* court reached its decision because "ERISA's remedial structure presents a detailed reasoned compromise between plan participants' need for adequate disclosure and the disincentives expansive liability for nondisclosure might present to employers considering institution" of ERISA plans.

In this case, neither under a "reasonable expectation" or estoppel theory may Plaintiffs avoid the binding effect of the Plan's exclusion.

Further, with regard to GPA's initial payment of medical benefits, Plaintiffs' reliance upon *Pitts By and Through Pttls v. American Sec. Life Ins. Co.,* 931 F.2d 35 1 (5th Cir. 1991) is misplaced. In *Pitts,* the Fifth Circuit found that the insurer had waived a condition of the policy upon which it attempted to rely in denying coverage. The group policy at issue in that case required a minimum number often employees to enroll before coverage would be effective. However, the insurer in that case accepted premiums from the employer on the group policy for five months after knowing for all five months, "beyond all doubt," that the insured was the only person remaining on the policy. Thus, it was absolutely clear that the number of enrollees to the policy fell well below the number required for quite some time. In this case there is no knowing and intentional waiver on the part of Defendants to waive the work-related exclusion. GPA merely timely paid medical benefits while it simultaneously investigated the circumstances upon which Mr. Murray became injured.

E. Alternatively, Plaintiffs argue Defendants failed t provide a summary plan description.

Alternatively, Plaintiffs seek administrative penaltie against Defendants for failure to timely provide a SPD. 2 U.S.C. § 1132(c)(l). Although Plaintiffs state that none of th Defendants have ever furnished Plaintiffs with a SPD [3], th Court understands their argument to be that the 1999 SPI notice was ineffective because it was done in an electroni format, and the SPD was not easily retrievable withi Crossmark's computer system. Defendants complain tha Plaintiffs have never pled a claim under 1132(c)(1) Alternatively, GPA and CGLLC/CIGNA argue tha administrative penalties under that section may only b assessed against the Plan Administrator Crossmark, not third party claim administrators.

ERISA's administrative penalty provision provides fo the assessment of civil penalties against the plan administrato The relevant text of29 U.S.C. § I 132(c)(1)(B) provides that:

> Any administrator . . . who fails or refuses to compl with a request for any information which sucl administrator is required by this subchapter to furnish t a participant or beneficiary (unless such failure o refusal results from matters reasonably beyond th control of the administrator) by mailing the materia requested to the last known address of the requestin participant or beneficiary within 30 days after sucl request may in the court's discretion be personally liabl to such participant or beneficiary in the amount of up t

---

[3] It is uncertain from the summary judgment evidence whether Plaintiffs, prior to or after Mr. Murray's injury, ever requested a copy of the SPD.

> $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

The term "administrator" refers to the person specifically designated by the terms of the instrument, or, if an administrator is not so designated, the plan sponsor. 29 U.S.C. § 1002(16)(A)(i) and (ii).

Crossmark is designated in the SPD as the administrator. Accordingly, Plaintiffs are unable to assert claims against either GPA or COLIC/CIGNA. Accordingly, summary judgment in favor of GPA and CGLIC/CIGNA is proper as to any 29 U.S.C. § 1132(c) claim. *See also Newell ex rel. Snow v. Aetna Life Ins. Co.,* 2002 WL 1840925, at *3 (N. D. Tex. Aug 08, 2002).

With regard to Crossmark, Plaintiffs presume that a "hard copy" of the SPD must be handed to an employee or plan participant. The federal regulations implementing ERISA's disclosure requirements, however, provide for electronic notification. *See* 29 C.F.R. 2520. 104b- 1(c)(1)(i), (iii), and (iv). However, the regulations also provide that electronic notification is satisfactory only if "the administrator takes appropriate and necessary measures reasonably calculated to ensure that the system for furnishing documents results in actual receipt of transmitted information." *Id.* Neither party has adequately addressed the issue of whether electronic communication of the SPD met this standard. While Crossmark argues that a claim for administrative penalties has not been pled, it appears that the issue of whether the SPD was properly transmitted to Plaintiffs has been an issue since the date Mr. Murray was injured. Given that Defendant Crossmark has not been surprised or prejudiced by the Plaintiffs' failure to specifically plead a 1132(c)(1) claim in the Complaint, the

Court will allow Plaintiffs to amend their Complaint to asse such a claim against Crossmark.

In the alternative, Crossmark, relying upon *Hatteberg v Red Adair Co., Inc. Employees' Profit Sharing Plan and it Related Trust,* 79 Fed. Appx. 709, 715 (5th Cir. 2003),[4] argue that even if Plaintiff could assert a 1132(c) claim, such a clain would be barred by the four year limitations period. Crossmar asserts that the four-year period began in 1996, when Plaintif first enrolled in her employer's medical plan. The Court however, finds that fact issues exist regarding when th limitations period began. The summary judgment evidenc tendered to the Court indicates that Crossmark did not begin it electronic posting of the SPD until 1999. There is no evidenc before the Court that SPDs were provided to employees prio to that date. Because Plaintiff filed her suit in 2003, her caus of action for statutory penalties may be well within the fou year limitation period.

Conclusion

The Court concludes that, for the reasons stated above Defendants' motions for summary judgment is GRANTED, ir part (docket no. 52). The Court concludes that the medical plar offered by Crossmark, and administered by GPA and late CGLIC/CIGNA is an "employee benefit plan" under ERISA. Under this plan, the Plan Administrator's decision to deny benefits under the work-injury exclusion was not arbitrary and capricious. Plaintiffs are therefore not entitled to recove benefits under the plan.

---

[4]Under the Fifth Circuit's Rule *47.5.4,* decisions not selected for publication carry no precedential weight, but may be used as persuasive authority.

The Court further concludes that Plaintiffs' motion for partial summary judgment is DENIED (docket no. 54). The Court, without deciding that exclusions in an ERISA plan are affirmative defenses subject to Federal Rule of Civil Procedure 8(c), finds that Defendants' failure to plead them did not result in waiver because Plaintiffs were not surprised or prejudiced. Thus, Defendants are not barred from asserting their exclusionary defense. In addition, the Court refuses to adopt the doctrine of reasonable expectations in the ERISA context. However, because a fact issue exists as to whether Crossmark adequately provided a SPD to Plaintiffs, Plaintiffs may amend their Complaint to assert this cause of action.

It is ORDERED that Plaintiffs must amend their pleading within 10 days to add their section 1132(c) claim.

Plaintiffs and Crossmark are ORDERED to submit this case to mediation within the next 30 days. The Court has attached a list of mediators. If the parties cannot agree to a mediator within the next 15 days, Plaintiffs are to notify the Court of this fact, and the Court will thereafter appoint a mediator.

The Court concludes that a fact issue exists as to whether Plaintiffs, prior to or after Mr. Murray's injury, ever requested a copy of the SPD, whether Crossmark satisfactorily provided Plaintiffs a copy of the SPD, and whether the 1132(c) claim is barred by limitations. Thus, if mediation is not successful, it is FURTHER ORDERED that Plaintiffs and Crossmark submit additional briefing within 20 days regarding the 1132(c) claim.

It is FURTHER **ORDERED** that all claims again GPA and CGLIC/CIGNA are dismissed.

SIGNED this 22
day of July, 2004

XAVIER RODRIGUEZ
UNITED STATES DISTRICT JUDGE

29 U.S.C. 1001(b)

"(b) Additional findings

The Congress further finds that modification of the current termination insurance system and an increase in the insurance premium for single-employer defined benefit pension plans (1) is desirable to increase the likelihood that full benefits will be paid to participants and beneficiaries of such plans;

* * *

(c) Declaration of policy

It is hereby declared to be the policy of this title * * * (3) to increase the likelihood that participants and beneficiaries under single-employer defined benefit pension plans will receive their full benefits. . . ."

29 U.S.C. 1022. Summary Plan Description

"(a) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries. . . . The summary plan description shall include the information described in subsection (b) of this section, shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.

(b) The summary plan description shall contain the following information: * * * the plan's requirements respecting eligibility for participation and benefits. . . ."

29 U.S.C. 1024 (b) Publication of summary plan description and annual report to participants and beneficiaries of plan.

"Publication of the summary plan descriptions and annua reports shall be made to participants and beneficiaries of th particular plan as follows:

(1) The administrator shall furnish to each participant, and eac beneficiary receiving benefits under the plan, a copy of th summary plan description, and all modifications and change * * * (B)If there is a modification or change described i section 1022 (a) of this title that is a material reduction i covered services or benefits provided under a group health pla . . . a summary description of such modification or change sha be furnished to participants and beneficiaries not later than 6 days after the date of the adoption of the modification c change."

29 U.S.C. 1133. Claims Procedure.

"In accordance with regulations of the Secretary, ever employee benefit plan shall (1) provide adequate notice i writing to any participant or beneficiary whose claim fc benefits under the plan has been denied, setting forth th specific reasons for such denial, written in a manner calculate to be understood by the participant, and (2) afford a reasonabl opportunity to any participant whose claim for benefits ha been denied for a full and fair review by the appropriate name fiduciary of the decision denying the claim."

29 C.F.R. 2520.104b-. Disclosure.

"(a) *General disclosure requirements.* The administrator of an employee benefit plan covered by Title I of the Act must disclose certain material, including reports, statements, notices, and other documents, to participants, beneficiaries and other specified individuals.

* * *

(c) *Disclosure through electronic media.*

(1) ... the administrator of an employee benefit plan furnishing documents through electronic media is deemed to satisfy the requirements of paragraph (b)(1) of this section with respect to an individual described in paragraph (c)(2) if:

(i) The administrator takes appropriate and necessary measures reasonably calculated to ensure that the system for furnishing documents (A) Results in actual receipt of transmitted information (e.g., using return-receipt or notice of undelivered electronic mail features, conducting periodic reviews or surveys to confirm receipt of the transmitted information) * * * (iii) Notice is provided to each participant, beneficiary or other individual ... of the right to request and obtain a paper version of such document; and (iv) Upon request, the participant, beneficiary or other individual is furnished a paper version of the electronically furnished documents.

(2) Paragraph (c)(1) shall only apply with respect to * * * (ii) A participant, beneficiary or any other person entitled to documents . . . who (A) . . . has affirmatively consented * * * (C) Prior to consenting, is provided . . . a clear and conspicuous statement indicating: (4) The right to request and obtain a paper version. . . ."

29 C.F.R. 2520.104b-3. Material Modifications

"(d) *Special rule for group health plans*—(1) *General.* ...Th administrator of a group health plan ... shall furnish to eac participant covered under the plan a summary, written in manner calculated to be understood by the average pla participant, of any modification to the plan or change in th information required to be included in the summary pla description, within the meaning of paragraph (a) of this sectio that is a material reduction in covered services or benefits n later than 60 days after the date of adoption of the modificatio or change."

29 C.F.R. 2520.107-1. Use of Electronic Media.

"(b) *General requirements.* The record maintenance and retention requirements of sections 107 and 209 of ERISA ar satisfied when using electronic media if * * * (3) The electronic records are readily convertible into legible and readable paper copy as may be needed to satisfy reporting and disclosure requirements or any other obligation under Title I of ERISA."

29 C.F.R. 2560.503-1. Claims Procedure.

"(a) *Scope and purpose.* ...[T]his section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants).

* * *

(b) *Obligation to establish and maintain reasonable claims procedures.* Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The claims procedures for a plan will be deemed to be reasonable only if

* * * (2) A description of all claims procedures ... and the applicable time frames is included as part of a summary plan description . . .; (3) The claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits * * * (5) The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents

* * *

(g) *Manner and content of notification of benefit determination* (1) . . . [T]he plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. . . . The notification shall set forth, in a manner calculated to be understood by the claimant (i) The specific reason or reasons for the adverse determination; (ii) Reference to the specific plan provisions on which the determination is based;

* * *

(h) *appeal of adverse benefit determinations* * * * (3) *Grou health plans.* The claims procedures of a group health plan wil not be deemed to provide a claimant with a reasonabl opportunity for a full and fair review of a claim and advers benefit determination unless . . . the claims procedures * * (ii) Provide for a review that does not afford deference to th initial adverse benefit determination and that is conducted by a appropriate named fiduciary of the plan who is neither th individual who made the adverse benefit determination that i the subject of the appeal, nor the subordinate of suc individual."

ACKNOWLEDGMENT OF SERVICE

I, EDWARD L. PINA, certify that today, April _____, 2006, a copy of the Petition for a Writ of Certiorari was served in accordance with Supreme Court Rule 29(3) on all parties required to be served by their counsel of record as indicated below:

Crossmark Sales, Inc.
and Group & Pension Administrators, Inc.
By:
Ms. Melissa M. Goodman
Haynes & Boone
901 Main Street, Suite 3100
Dallas, Texas 75202

Connecticut General Life Insurance Co.
By:
Mr. Scott Field
Cork, Keller & Field
816 Congress Avenue
Frost Bank Plaza, Suite 1265
Austin, Texas 78701

EDWARD L. PINA
Counsel of Record for Petitioners
EDWARD L. PINA & ASSOCIATES
8118 DATAPOINT DRIVE
SAN ANTONIO, TEXAS 78229
(210) 614-6400

(1)

No. 05-1350

FILED
JUN 26 2006
OFFICE OF THE CLERK
SUPREME COURT, U.S.

In the Supreme Court of the United States

NEVA MURRAY, INDIVIDUALLY AND AS GUARDIAN OF HUGH MURRAY, WARD,
Petitioner,

v.

CROSSMARK SALES, INC.; CONNECTICUT GENERAL LIFE INSURANCE CO.; and GROUP & PENSION ADMINISTRATORS, INC.,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF IN OPPOSITION

W. ALAN WRIGHT
Counsel of Record
MELISSA M. GOODMAN
LAURA E. O'DONNELL
HAYNES AND BOONE, LLP
901 MAIN STREET, SUITE 3100
DALLAS, TX 75202
(214) 651-5000

Counsel for Respondents CROSSMARK Sales, Inc., and Group & Pension Administrators, Inc.

Becker Gallagher Legal Publishing, Inc. 800.890.5001

QUESTIONS PRESENTED

1. Should this Court reconsider the well-settled standard of review of a plan administrator's decision to deny benefits under Section 502(a)(1)(B) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a)(1)(B), as set out in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), where the Petitioner raised no challenge to the standard of review in the District Court or Court of Appeals, and the ERISA plan exclusion at issue unambiguously precludes recovery?

2. Should this Court review the treatment by the lower courts in this case of the doctrine of reasonable expectations in the context of an ERISA plan where there is no circuit split concerning the doctrine, and the prerequisites for application of the doctrine – an ambiguous or inconspicuous plan exclusion – are not present?

3. Should this Court review the denial of benefits in an ERISA case in which two of the Respondents – Group & Pension Administrators, Inc. and Connecticut General Life Insurance Company – cannot be held liable for benefits to Petitioner because they did not serve as plan administrator and were merely third-party claims administrators of Respondent CROSSMARK's self-funded plan?

PARTIES TO THE PROCEEDINGS BELOW

Respondents CROSSMARK, Inc. and Group & Pension Administrators, Inc., make this Disclosure of Corporate Affiliations and Corporate Interest pursuant to SUP. CT. R. 29.6, and would respectfully show the Court as follows:

A. Petitioner is Neva Murray, Individually and as Guardian of Hugh Murray, Ward.

B. Respondents are CROSSMARK, Inc.; Connecticut General Life Insurance Company; and Group & Pension Administrators, Inc.

RULE 29.6 STATEMENT

CROSSMARK Holdings, Inc. is the parent corporation to Respondent CROSSMARK, Inc. ("CROSSMARK"). There are no publicly held corporations that own 10% or more of CROSSMARK's stock.

GPA Holdings, Inc. is the parent corporation to Respondent Group & Pension Administrators, Inc. ("GPA"). There are no publicly held corporations that own 10% or more of GPA's stock.

Respondent Connecticut General Life Insurance Company ("CIGNA") identifies the following potentially interested parties who are related to it: CIGNA Corporation, which is a publicly held corporation, CIGNA Holdings, Inc., and Connecticut General Corporation.

Aside from the subsidiary and affiliate relationships described above, there are no publicly owned corporations, not a party to the appeal, with a financial interest in the outcome of this appeal.

TABLE OF CONTENTS

Questions Presented i

Parties to the Proceedings Below ii

Rule 29.6 Statement iii

Introduction 1

Statement of the Case 2

I. BACKGROUND FACTS 2

II. PETITIONER HAD ACCESS TO THE SPD, WHICH HAS ALWAYS EXCLUDED CHARGES INCURRED FOR WORK-RELATED INJURIES 3

III. PETITIONER'S HUSBAND SUFFERED A WORK-RELATED INJURY 5

IV. THE ADMINISTRATORS CORRECTLY DENIED CLAIMS ARISING FROM MR. MURRAY'S WORK-RELATED INJURIES 6

V. PROCEDURAL HISTORY 7

VI. PETITIONER'S MATERIAL MISREPRESENTATIONS 9

Reasons the Writ Should be Denied 10

I. THE COURT SHOULD DECLINE TO CONSIDER PETITIONER'S BELATED CHALLENGE TO ERISA'S ABUSE OF DISCRETION STANDARD OF REVIEW . . 10

A. Petitioner has waived any arguments relating to the appropriate standard of review 11

B. There is no Circuit Court split or "rising judicial chorus" that would justify reconsideration of the well-established standard of review framework established by the Court in *Firestone Tire* 11

C. *Firestone Tire* does not require deference to the plan administrator's decision in every case 13

D. Alleged procedural violations of ERISA do not change the standard of review 14

E. The outcome of this case would be the same under *de novo* review 18

II. THE COURT SHOULD DECLINE TO CONSIDER PETITIONER'S CHALLENGE TO THE REASONABLE EXPECTATIONS DOCTRINE 19

A. The District Court correctly concluded that the reasonable expectations doctrine would not apply to the work-related exclusion in this case 19

1. The SPD Exclusions are clear, plain and conspicuous 21

2. The GPA SPD's work-related exclusion is not ambiguous 23

3. The CIGNA SPD's pre-existing condition exclusion is not ambiguous and Petitioner waived this argument 24

B. The Fifth Circuit did not reject the reasonable expectations doctrine 25

C. The courts of appeals are not split with respect to the reasonable expectations doctrine 25

III. GPA AND CIGNA CANNOT BE LIABLE FOR PAYMENT OF BENEFITS UNDER THE PLAN 29

Conclusion 30

Appendix 1b

TABLE OF AUTHORITIES

Cases

Aetna Health Inc. v. Davila,
542 U.S. 200 (2004) 11, 12

Allison v. UNUM Life Ins. Co. of Am.,
381 F.3d 1015 (10th Cir. 2004) 13

Babikian v. Paul Revere Life Ins. Co.,
63 F.3d 837 (9th Cir. 1995) 20, 22

Butts v. Cont'l Cas. Co.,
357 F.3d 835 (8th Cir. 2004) 13

Bynum v. CIGNA Healthcare of N.C., Inc.,
287 F.3d 305 (4th Cir. 2002) 20, 27

California v. Taylor,
353 U.S. 553 (1957) 11, 24

Carr v. Reliance Standard Life Ins. Co.,
363 F.3d 604 (6th Cir. 2004) 28

Colucci v. Agfa Corp. Severance Pay Plan,
431 F.3d 170 (4th Cir. 2005),
cert. denied, 164 L.Ed. 2d 815 (2006) 12

Daniel v. Eaton Corp.,
839 F.2d 263 (6th Cir.),
cert. denied, 488 U.S. 826 (1988) 30

Estate of Shockley v. Alyeska Pipeline Svc. Co.,
130 F.3d 403 (9th Cir. 1997) 27, 29

Everhart v. Allmerica Fin. Life Ins. Co.,
275 F.3d 751 (9th Cir. 2001),
cert. denied, 536 U.S. 958 (2002) 30

Firestone Tire & Rubber Co. v. Bruch,
489 U.S. 101 (1989) . . . . . *passim*

Gallagher v. Reliance Standard Life Ins. Co.,
305 F.3d 264 (4th Cir. 2002) 27

Garren v. John Hancock Mut. Life Ins. Co.,
114 F.3d 186 (11th Cir. 1997) 30

Gibbs v. CIGNA Corp.,
440 F.3d 571 (2d Cir. 2006) 12

Henglein v. Informal Plan for Plant Shutdown Benefits for Salaried Employees,
974 F.2d 391 (3d Cir. 1992) 25

Hines v. Mass. Mut. Life Ins. Co.,
43 F.3d 207 (5th Cir. 1995) 15

Jass v. Prudential Health Care Plan, Inc.,
88 F.3d 1482 (7th Cir. 1996) 30

Jordan v. Northrop Grumman Corp. Welfare Benefit Plan,
370 F.3d 869 (9th Cir. 2004) 13

Kimber v. Thiokol Corp.,
196 F.3d 1092 (10th Cir. 1999) 29

Lawn v. United States,
355 U.S. 339 (1958) 11, 24

Layes v. Mead Corp.,
132 F.3d 1246 (8th Cir. 1998) 30

Lee v. Burkhart,
991 F.2d 1004 (2d Cir. 1993) 30

Lifson v. INA Life Ins. Co.,
333 F.3d 349 (2d Cir. 2003) 27-28

Madera v. Marsh USA, Inc.,
426 F.3d 56 (1st Cir. 2005) 12

Marquette Gen. Hosp. v. Goodman Forest Indus.,
315 F.3d 629 (6th Cir. 2003) 23, 28

McCall v. Burlington Northern/Santa Fe Co.,
237 F.3d 506 (5th Cir. 2000),
cert. denied, 534 U.S. 822 (2001) 14

McCartha v. Nat'l City Corp.,
419 F.3d 437 (6th Cir. 2005) 12-13

McClure v. Life Ins. Co. of N. Am.,
84 F.3d 1129 (9th Cir. 1996) 20

Mello v. Sara Lee Corp.,
431 F.3d 440 (5th Cir. 2005) 12

Peterson v. Am. Life & Health Ins. Co.,
48 F.3d 404 (9th Cir.),
cert. denied, 516 U.S. 942 (1995) 20

Pirkheim v. First Unum Life Ins.,
229 F.3d 1008 (10th Cir. 2000) 20

Ruiz v. Cont'l Cas. Co.,
400 F.3d 986 (7th Cir. 2005) 13

Ruttenberg v. United States Life Ins. Co.,
413 F.3d 652 (7th Cir. 2005) 28

Saltarelli v. The Bob Baker Group Med. Trust,
35 F.3d 382 (9th Cir. 1994) 19, 20, 22, 26

Sunbeam-Oster Co. Group Benefits Plan for Salaried and Non-Bargaining Hourly Employees v. Whitehurst,
102 F.3d 1368 (5th Cir. 1996) 2

Tillery v. Hoffman Enclosures, Inc.,
280 F.3d 1192 (8th Cir. 2002) 15

Torres v. Pittston Co.,
346 F.3d 1324 (11th Cir. 2003) 13

United States v. Williams,
504 U.S. 36 (1992) 11, 24

Vercher v. Alexander & Alexander Inc.,
379 F.3d 222 (5th Cir. 2004) 13

Vitale v. Latrobe Area Hosp.,
420 F.3d 278 (3d Cir. 2005) 12

Wheeler v. Dynamic Eng'g, Inc.,
62 F.3d 634 (4th Cir. 1995) 20, 27

Winters v. Costco Wholesale Corp.,
49 F.3d 550 (9th Cir.),
cert. denied, 516 U.S. 908 (1995) 20, 22, 27

Winterstein v. Stryker Corp. Group Life Ins. Plan,
157 F. App'x 20 (9th Cir. 2005) 27

Statutes and Regulation

29 C.F.R. § 2520.102-2(b) 21

29 U.S.C. § 1024(b)(1) 4, 5

29 U.S.C. § 1104(a)(1)(D) 14, 16

29 U.S.C. § 1131 17

29 U.S.C. § 1132(a)(1)(B) 7, 8, 30

29 U.S.C. § 1132(a)(2) 14

29 U.S.C. § 1132(a)(3) 12, 14

29 U.S.C. § 1132(c)(1) 8

29 U.S.C. § 1132(c)(1)(B) 14

Rules

Sup. Ct. R. 10 19

Sup. Ct. R. 15.2 9

INTRODUCTION

Petitioner Neva Murray is a participant in Respondent CROSSMARK, Inc.'s ("CROSSMARK") employee welfare benefit plan ("Plan"), which, since at least 1997, has excluded coverage for work-related injuries. Petitioner enrolled her husband in the Plan as a dependent on March 29, 2000. Petitioner admits her husband was injured while on the job in February 2001 and that the Plan contains an exclusion for work-related injuries. These facts are fatal to Petitioner's claim, and it was on this basis that Respondents GPA and CIGNA, the claims administrators for CROSSMARK's Plan during the relevant time period, denied benefits.

Recognizing the effect of these undisputed facts, Petitioner turns to arguments not presented to the Court of Appeals or the District Court and relies on purported facts not supported by the appellate record. Petitioner argues that even if the Plan document grants a claims administrator discretion, the abuse of discretion standard should not necessarily apply. Petitioner requests that this Court overturn its decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), 17 years after it was decided and during which time nearly every employer in the United States that offers benefits to its employees has followed the Court's direction in deciding the amount of discretion to confer to plan fiduciaries. Petitioner requests such relief for the first time in this Court, and she does so in the absence of any conflict among the circuits on this issue.

Petitioner also requests that the Court decide whether the doctrine of reasonable expectations applies in all ERISA denial of benefits cases. Contrary to Petitioner's argument, there is not a split among the circuits and this case does not provide an appropriate platform for addressing any such alleged conflict. In addition, the Plan exclusion at issue was

conspicuous and unambiguous. For the doctrine of reasonable expectations to apply in any circuit, a finding of either inconspicuousness or ambiguity is required. Thus, even if this case otherwise provided a vehicle for deciding whether the doctrine of reasonable expectation applies, the facts of the case do not support full consideration of the issue.

For these reasons and those stated below, Respondents respectfully submit that the Court deny Petitioner's petition.

STATEMENT OF THE CASE

I. BACKGROUND FACTS.

CROSSMARK is a professional services company that helps consumer packaged goods manufacturers and retailers reach their performance goals. CROSSMARK employs more than 15,000 employees world-wide. CROSSMARK was formed in 1995 through a merger of three sales and marketing companies. CROSSMARK and its predecessors have sponsored a health and welfare employee benefit plan for its employees since its inception. The CROSSMARK medical Plan is a self-funded plan that provides medical, prescription drug and vision benefits to Plan participants and beneficiaries by making payments or reimbursements pursuant to the terms of the Plan Document and Summary Plan Description ("SPD").[1] Resp. App. 3b, 4b, 9b.

Petitioner is employed with CROSSMARK, and has participated in CROSSMARK's medical Plan since 1996. Petitioner signed an enrollment application stating that she

---

[1] Courts have recognized that the plan document and SPD are often the same document for a self-insured plan like CROSSMARK's Plan. *See Sunbeam-Oster Co. Group Benefits Plan for Salaried and Non-Bargaining Hourly Employees v. Whitehurst*, 102 F.3d 1368, 1375 (5th Cir. 1996).

agreed to be bound by the terms and conditions of the Summary Plan Description and Plan Document.

CROSSMARK is the Plan administrator, but it delegates claims administration to a third-party claims administrator who has the discretion and authority to make benefit determinations. Pet. App. 2. In 1997, GPA became the claims administrator for the Plan. As administrator, GPA determined which claims for benefits should be paid under the terms of the SPD. Pet. App. 2; Resp. App. 8b, 9b. On March 29, 2000, Petitioner enrolled her husband, Hugh Murray, as a dependent beneficiary in the Plan because he started his own pest control business, Admiral Pest Control, Inc., with a partner and no longer had other health insurance. Pet. App. 2.

On March 1, 2001, CROSSMARK replaced GPA with CIGNA as claims administrator. Thus, effective March 1, 2001, CIGNA exercised its discretion to make benefit determinations under the Plan for claims occurring on or after March 1, 2001. Pet. App. 2.

II. Petitioner Had Access To The SPD, Which Has Always Excluded Charges Incurred For Work-Related Injuries.

When Petitioner enrolled in the Plan, the SPD was available to all participants through CROSSMARK's Human Resources Department. In 1999, CROSSMARK distributed the SPD to participants, including Petitioner, by posting it in CROSSMARK 's Public Folders on its computer system. Petitioner had access to the SPD through her computer at her work station and CROSSMARK informed Petitioner how to access the SPD on its computer system. Petitioner also knew she could call GPA, access GPA's website, contact CROSSMARK's Benefits Department, or call CIGNA (once

it became the claims administrator) if she had questions about the Plan or SPD.

Since at least 1997, when GPA became the CROSSMARK Plan's claims administrator, the Plan has excluded from coverage any charges arising out of any occupation for wage or profit. Specifically, the SPD stated:

> The following exclusions and limitations apply to expenses incurred by all Covered Persons:
>
> 3. Charges arising out of or in the course of any occupation for wage or profit, or for which the Covered Person is entitled to benefits under any Worker's Compensation or Occupational Disease Law, or any such similar law.

Resp. App. 10b (referred to herein as the "work-related" exclusion). This work-related exclusion is a common exclusion in employee benefit plans under ERISA.

When CIGNA replaced GPA as the claims administrator, certain amendments to the schedule of benefits became effective on March 1, 2001. Resp. App. 24b, 25b. In January 2001, CROSSMARK gave its employees notice of these material Plan changes through a Summary of Material Modifications ("SMM"), as required by ERISA, Section 104(b)(1) (29 U.S.C. § 1024(b)(1)), which were set forth in an Enrollment Guide and Benefits Summary. Resp. App. 24b, 25b. CROSSMARK did not materially change the work-related exclusion. Accordingly, the SMM did not reference the exclusion. In July 2001, CROSSMARK issued an amended SPD, which incorporated the changes that had been

previously explained in the SMM.[2] Like GPA had done, CIGNA provided a "form" SPD for CROSSMARK's use; therefore, some of the language and format between the GPA-administered SPD ("GPA SPD") and the CIGNA-administered SPD ("CIGNA SPD" or "amended SPD") may have differed where the Plan terms did not change. Like the GPA SPD, the amended SPD contains a work-related injury exclusion:

> No payment will be made for expenses incurred for you or any one of your Dependents:
>
> - for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit.

Resp. App. 2b.

III. PETITIONER'S HUSBAND SUFFERED A WORK-RELATED INJURY.

On February 12, 2001, Mr. Murray fell through a ceiling from an attic onto a concrete floor while performing his pest control job duties at a customer's house for profit. Resp. App. 19b, 20b.

---

[2] Under ERISA, Section 104(b)(1) (29 U.S.C. § 1024(b)(1)), a plan administrator is only required to issue an amended summary plan description which integrates all plan amendments every five years. Even when a plan administrator does issue an amended plan, a plan administrator has 210 days after the end of the plan year for which the change is adopted to issue the amended summary plan description. This means that, although CROSSMARK was not required to issue an amended SPD until January 2004, since it did so, CROSSMARK had until September 26, 2002 to provide Petitioner an amended SPD. CROSSMARK distributed the amended SPD to participants and beneficiaries, including Petitioner, in July 2001 - well before ERISA's required deadline. Resp. App. 25b.

Once GPA began receiving claims arising out of Mr. Murray's February 12, 2001 accident, it initiated an investigation to determine whether those claims were covered by the Plan. As part of its investigation, on May 11, 2001, GPA sent Petitioner a request for more information about Mr. Murray's injuries. Resp. App. 11b, 12b, 13b. On May 29, 2001, Petitioner submitted a statement to GPA and CROSSMARK in connection with GPA's eligibility determination, and admitted--in her own writing--that Mr. Murray's injuries were work-related:

> Was the accident related in any way to your work? ***Yes***
>
> If yes, please explain: ***Was on job.... Self employed—Admiral Pest Control 7126 Eckhert Rd. Ste 211, San Antonio; 78238.***

Resp. App. 11b, 12b, 13b. ("May 29, 2001 statement").

IV. THE ADMINISTRATORS CORRECTLY DENIED CLAIMS ARISING FROM MR. MURRAY'S WORK-RELATED INJURIES.

After GPA (a) received Petitioner's May 29, 2001 statement in which she stated that Mr. Murray's injuries were work-related, and (b) reviewed the Plan terms, GPA determined that claims arising from Mr. Murray's injury were excluded from coverage under the Plan's work-related exclusion. In early June 2001, GPA began sending denial of benefits notices to Petitioner, indicating that Mr. Murray's injuries were not covered because "CHARGES INCURRED AS A RESULT OF AN ON THE JOB INJURY OR ILLNESS ARE DENIED ACCORDING TO THE MAJOR MEDICAL EXCLUSIONS IN YOUR SUMMARY PLAN DESCRIPTION." CROSSMARK also instituted its own investigation and likewise concluded that Mr. Murray's

injuries were expressly excluded under the Plan's terms. Pet. App. 3.

Because of the change in the entity administrating claims, Petitioner submitted claims for expenses incurred after March 1, 2001 to CIGNA. Unlike GPA, CIGNA utilizes what it calls a "pay and chase" system of claims administration. Consistent with this system, CIGNA initially paid Petitioner based upon the claims received and then instituted an investigation. CIGNA paid approximately $90,000 in benefits, but after investigation, determined that Mr. Murray's claims were barred by the work-related exclusion. Resp. App. 14b, 15b. Petitioner contested the denials and, in its role as claims administrator at that time, CIGNA affirmed the decision to deny Mr. Murray's benefit claims. Resp. App. 16b, 17b; Pet. App. 4.

V. PROCEDURAL HISTORY.

Challenging the administrators' decisions to deny claims arising from Mr. Murray's work-related injuries, Petitioner filed this lawsuit against Respondents, asserting only a denial of benefits claim under Section 502(a)(1)(B) of ERISA (29 U.S.C. § 1132(a)(1)(B)) in her Second Amended Complaint.

CROSSMARK and GPA moved for summary judgment in the District Court on the grounds that Respondents' denial of benefits to Mr. Murray based on the unambiguous language of the Plan exclusions was not an abuse of discretion. CIGNA joined the motion. Petitioner also moved for partial summary judgment. Pet. App. 9. The District Court denied Petitioner's motion for partial summary judgment and granted a complete summary judgment in favor of GPA and CIGNA. Pet. App. 9-22.

The District Court granted summary judgment to CROSSMARK on Petitioner's denial of benefits claim under ERISA, Section 502(a)(1)(B). In its summary judgment

Order, the District Court determined that (i) the work-related exclusion was unambiguous, and (ii) it was undisputed that Mr. Murray's injuries were work-related. The District Court also noted that Petitioner did "not dispute that the plan administrator had discretionary authority to construe that plan or that the administrator's decision was not arbitrary or capricious." Pet. App. 13. Based on the undisputed facts, the District Court concluded that the administrators did not abuse their discretion in denying Mr. Murray's claim for benefits arising from his work-related injuries because such claims were excluded by the plain terms of the SPD. In its decision, the District Court rejected Petitioner's arguments that (i) the Plan exclusion was an affirmative defense that was not pled and was waived, and (ii) the reasonable expectations doctrine compelled judgment for Petitioner. However, the District Court determined that Petitioner could amend her Complaint to assert a claim against CROSSMARK for statutory penalties under ERISA, Section 502(c)(1) (29 U.S.C. §1132(c)(1)), for alleged failure to timely provide her an SPD upon her request. The parties settled Petitioner's Section 502(c)(1) claim, it was dismissed with prejudice, and was not part of her appeal to the Fifth Circuit. Pet. App. 7.

In Petitioner's appeal to the Fifth Circuit, she raised the same arguments as she did at the District Court. Petitioner did not contest that the appropriate standard of review for her Section 502(a)(1)(B) claim was abuse of discretion. The Fifth Circuit concluded that (i) the District Court did not err in concluding that the work-related exclusion defense was not waived, and (ii) the District Court did not err in concluding that the denial of benefits under the unambiguous terms of the work-related exclusions was neither arbitrary nor capricious. Pet. App. 5-6.

VI. PETITIONER'S MATERIAL MISREPRESENTATIONS.

Consistent with Rule 15.2 of this Court's Rules, Respondents note Petitioner's material misrepresentations of the appellate record. The judgment of the District Court and the Fifth Circuit was based on cross-motions for summary judgment, and only those facts contained in the summary judgment record may be considered on appeal to this Court. Petitioner, however, proffers several alleged "facts" that are not supported by evidence and are not contained in the appellate record.

For example, Petitioner states on page 3 of her Petition that "once CIGNA assumed administrative duties on March 1, 2001, it administered the Crossmark plan without benefit of any governing documents – whether SPD or plan – until July, 2001." This is a misstatement of the evidence. As stated above, the record demonstrates that when CIGNA became the claims administrator on March 1, 2001, it administrated claims under the GPA SPD and the SMM until the Plan was amended in July 2001, at which time CIGNA used the CIGNA SPD – which contained a substantively identical work-related exclusion to the GPA SPD.

Similarly, Petitioner incorrectly asserts that "CIGNA, months after learning of Mr. Murray's extensive claims, drafted its plan, separated out the worker's compensation and work-related exclusions into two separate exclusions, and placed the work-related exclusion as the first-listed one." Pet. 5. This statement is untrue and does not appear anywhere in the appellate record. In fact, the CIGNA SPD was drafted with no regard to Petitioner's claims and was a form used by CIGNA that contained the same work-related exclusion as the GPA SPD; the CIGNA SPD merely listed the exclusion separately rather than in a single paragraph with the workers' compensation exclusion like the GPA SPD.

Additionally, on Page 6 of the Petition, Petitioner states:

> Respondents indicated, in internal communications, that no administrator was to pay any benefits for Hugh Murray and instructed adjusters to deny all claims, in an apparent decision that all future health care needs by Mr. Murray related back to his accident. Claims for Mr. Murray's gastrointestinal and cardiac problems were thus denied.

This purported "fact" appears nowhere in the appellate record. In fact, Petitioner first attempted to make such a claim after the District Court granted summary judgment to Respondents. The District Court granted CROSSMARK's motion to strike this pleading, and Petitioner did not appeal the District Court's decision.

These misstatements by Petitioner should not be considered by this Court when deciding whether to grant Petitioner's petition.

REASONS THE WRIT SHOULD BE DENIED

I. THE COURT SHOULD DECLINE TO CONSIDER PETITIONER'S BELATED CHALLENGE TO ERISA'S ABUSE OF DISCRETION STANDARD OF REVIEW.

In her first question presented for review, Petitioner requests that this Court reconsider its holding in *Firestone Tire & Rubber v. Bruch*, 489 U.S. 101, 115 (1989), that the appropriate standard of review in a denial of benefits case of an ERISA administrator with discretion is abuse of discretion. According to Petitioner, this standard of review framework set out in *Firestone Tire* has proven untenable. To support this argument, Petitioner proffers several misleading and incorrect factual and legal assertions.

A. Petitioner has waived any arguments relating to the appropriate standard of review.

Petitioner did not dispute in the District Court or the Court of Appeals that the abuse of discretion standard of review applied in this case. In her Second Amended Complaint, Petitioner set forth the standard alleging denial of her benefit claims as "arbitrary and capricious" and did not challenge or complain of the application of that standard to her claims. Moreover, Petitioner did not appeal the District Court's application of the abuse of discretion standard of review to the Court of Appeals. Neither the District Court nor the Court of Appeals was presented with an opportunity to consider the challenge to the standard of review Petitioner now urges in this Court.

As a result, Petitioner's challenge to ERISA's abuse of discretion standard of review is waived and should not be considered by the Court. *See United States v. Williams*, 504 U.S. 36, 41 (1992); *Lawn v. United States*, 355 U.S. 339, 362 n.16 (1958); *California v. Taylor*, 353 U.S. 553, 556 n.2 (1957).

B. There is no Circuit Court split or "rising judicial chorus" that would justify reconsideration of the well-established standard of review framework established by the Court in *Firestone Tire*.

As a threshold to her argument, Petitioner relies on Justice Ginsburg's concurrence in *Aetna Health Inc. v. Davila,* 542 U.S. 200, 222 (2004) (Ginsburg, J., concurring), and asserts "it is time to recognize 'the rising judicial chorus urging that Congress and this Court revisit what is an unjust and increasingly tangled ERISA regime.'" Pet. 8. Petitioner then implies that *Aetna Health* supports the proposition that one of the "unjust and tangled ERISA regime" issues that should be reviewed by the Court is the appropriate standard of review

to be applied in a denial of benefits case under ERISA. Petitioner's far-fetched argument is not supported by the law or facts of this case.

First, *Aetna Health* did not involve the appropriate standard of review in a denial of benefits case; nor did it analyze a denial of benefits. Second, Justice Ginsburg's concurrence addressed a potential conflict between ERISA's broad preemptive scope and the limited equitable relief allowed for a claim asserted under Section 502(a)(3) of ERISA. Because Petitioner did not assert any Section 502(a)(3) claims or dispute ERISA's preemptive effect of her state law claims in this case, her reliance on Justice Ginsburg's concurrence in *Aetna Health* is misplaced.

Third, in the Court's unanimous decision in *Aetna Health*, the Court reiterated the well-established *Firestone Tire* standard of review analysis, without referencing any alleged conflict among the Circuits: "Any dispute over the precise terms of the plan is resolved by a court under a *de novo* review standard, unless the terms of the plan 'giv[e] the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.'" *Aetna Health*, 542 U.S. at 210 (quoting *Firestone Tire*, 489 U.S. at 115).

Fourth, Petitioner's contention is not supported by any case law. All circuit courts of appeals have consistently and uniformly followed *Firestone Tire*. *See, e.g., Madera v. Marsh USA, Inc.*, 426 F.3d 56, 63–64 (1st Cir. 2005); *Gibbs v. CIGNA Corp.*, 440 F.3d 571, 575 (2d Cir. 2006); *Vitale v. Latrobe Area Hosp.*, 420 F.3d 278, 281–82 (3d Cir. 2005); *Colucci v. Agfa Corp. Severance Pay Plan*, 431 F.3d 170, 175-76 (4th Cir. 2005), *cert. denied*, 164 L.Ed. 2d 815 (2006); *Mello v. Sara Lee Corp.*, 431 F.3d 440, 443–44 (5th Cir. 2005); *McCartha v. Nat'l City Corp.*, 419 F.3d 437,

441-42 (6th Cir. 2005); *Ruiz v. Cont'l Cas. Co.*, 400 F.3d 986, 989 (7th Cir. 2005); *Butts v. Cont'l Cas. Co.*, 357 F.3d 835, 838 (8th Cir. 2004); *Jordan v. Northrop Grumman Corp. Welfare Benefit Plan*, 370 F.3d 869, 874–75 (9th Cir. 2004); *Allison v. UNUM Life Ins. Co. of Am.*, 381 F.3d 1015, 1021 (10th Cir. 2004); *Torres v. Pittston Co.*, 346 F.3d 1324, 1328–29 (11th Cir. 2003).

C. *Firestone Tire* does not require deference to the plan administrator's decision in every case.

Petitioner incorrectly claims that a court is constrained in reviewing a benefit denial, because "in all but the rare case, lower federal courts following this Court's decision in *Firestone Tire & Rubber Co.*, must defer to the administrator's decision." Pet. 8. This Court did not hold that a lower court "must defer" to the administrator's decision. To the contrary, the Court held that "a denial of benefits . . . is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire*, 489 U.S. at 115.

Even under the abuse of discretion analysis, the plan administrator's decision must be (i) legally correct, and (ii) if it is not legally correct, must not constitute an abuse of discretion. *Vercher v. Alexander & Alexander Inc.*, 379 F.3d 222, 227 (5th Cir. 2004). To determine whether a plan administrator's decision is legally correct, a court considers: (1) whether the administrator has given the plan a uniform construction; (2) whether the interpretation is fair and reasonable, and (3) whether unanticipated costs would result from a different plan interpretation. *Id.* at 228. In determining whether the plan interpretation was an abuse of discretion, courts analyze whether it is an interpretation that

a reasonable person could have reached. *See, e.g., McCall v. Burlington Northern/Santa Fe Co.*, 237 F.3d 506, 512 (5th Cir. 2000), *cert. denied*, 534 U.S. 822 (2001). Thus, a court reviewing a benefit denial under an abuse of discretion standard must analyze the decision and determine whether it was reasonable.

D. Alleged procedural violations of ERISA do not change the standard of review.

Petitioner contends that alleged procedural violations of ERISA should necessarily trigger *de novo* review, notwithstanding *Firestone Tire*. She predicates her argument on false assertions.

First, Petitioner incorrectly argues that "since ERISA precludes statutory penalties, ERISA administrators have an incentive to deny all claims and force claimants to enter court." Pet. 8. To the contrary, ERISA *provides* for statutory penalties -- ERISA does not *preclude* statutory remedies. Indeed, in the District Court's summary judgment Order in this case, the court specifically allowed Petitioner to amend her Complaint and add a claim for statutory penalties under Section 502(c)(1)(B), which she did. Further, plan administrators do not "have an incentive to deny all claims and force claimants to enter court" because plan administrators have fiduciary duties under ERISA. ERISA requires that "a fiduciary shall discharge his duties with respect to a plan . . . in accordance with the documents and instruments governing the plan . . . " Section 404(a)(1)(b) (29 U.S.C. § 1104(a)(1)(D)). Fiduciaries can be held individually liable under ERISA for a breach of their duties. *See, e.g.*, Sections 502(a)(2), 502(a)(3).

Second, Petitioner alleges that judicial "deference is given to the plan administrator even if the administrator itself has grossly flouted ERISA's procedural safeguards for

employees/beneficiaries." Pet. 8. This allegation is without merit. There is no evidence in this case that the Plan administrator "grossly flouted ERISA's procedural safeguards." As previously noted, ERISA provides remedies for procedural violations, which Petitioner asserted in this case and the parties settled. In addition, courts have recognized that a procedural violation of ERISA may give rise to a substantive remedy (but not that it changes the standard of review) if the procedural violation is "continuous and amounts to substantive harm." *Hines v. Mass. Mut. Life Ins. Co.*, 43 F.3d 207, 211 (5th Cir. 1995). This case does not fit within the limited exception for a continuous violation that amounts to substantive harm. The District Court correctly determined that an alleged failure to furnish the SPD to Petitioner did not affect her substantive rights or the Plan administrator's benefit decision. Pet. App. 16. The District Court reasoned that Petitioner "cannot offer evidence that the plan administrator's decision was the product of an arbitrary decision or the plan administrator's whim. Plaintiffs are unable to overcome the fact that Mr. Murray was injured during the course of his employment, and the plan clearly excluded such injury from coverage." Pet. App. 16.

With respect to the settled alleged procedural violation, even if Petitioner undisputedly had received the SPD sooner, there was nothing she could have done to change the outcome in this case, because the Plan clearly excluded Mr. Murray's injury from coverage. As the District Court noted, the Eighth Circuit's decision in *Tillery v. Hoffman Enclosures, Inc.*, 280 F.3d 1192 (8th Cir. 2002) is instructive. Pet. App. 16

There "[t]he Tillerys also question whether they ever received a copy of the SPD. Assuming they did not, they fail to explain how such an oversight affected their substantive rights or the decision of the plan administrator." 280 F.3d at 1198. The administrator was required to discharge its duties

in accordance with the Plan terms, which specifically excluded work-related injuries from coverage. To ignore the exclusion would cause the administrator to breach its fiduciary duties.

See also Section 504(a)(1)(D) (29 U.S.C. § 1104(a)(1)(D)) ("a fiduciary shall discharge his duties with respect to a plan . . . in accordance with the documents and instruments governing the plan.").[3]

Next, Petitioner misleadingly posits the issue that "this Court has never explicitly decided the important question of whether backdated or post-hoc instruments may exclude claims for benefits under an ERISA welfare plan, as Respondents have done here. Thus, this Court has also never decided whether an abuse of discretion review is appropriate under these circumstances." Pet. 10. The issue posited by Petitioner is not presented by the facts in this case. As previously explained, Petitioner's contention that there was no SPD in this case is false. The District Court and the Fifth Circuit recognized that there was a Plan document and SPD in effect at all times. Pet. App. 2, 15-16. Additionally, the issue is waived because Petitioner never presented the issue to the lower courts. Further, Petitioner's repeated complaints concerning the alleged failure to provide her with an SPD were resolved by settlement in the District Court, and are not properly before this Court.

Disingenuously conflating two very distinct theories, Petitioner states "ERISA regulations require that plans

---

[3] Although Petitioner stated in her Petition that "the Fifth Circuit affirmed that decision [that the alleged failure to provide her an SPD did not amount to substantive harm] for essentially the reasons stated below" (Pet. 10), she did not appeal this issue to the Fifth Circuit, the Fifth Circuit did not analyze this issue, and it is waived.

provide notice in writing of the specific reasons for such denial, written in the manner calculated to be understood by the participant when denying benefits." Pet. 12 (citing ERISA Section 501, 29 U.S.C. § 1131). Petitioner next claims that the Fifth Circuit determined that ERISA's "specific reasons" for denial requirements were satisfied by Respondents by their general reference to "plan terms" in their answer to Petitioner's Complaint. Petitioner then concludes that the Fifth Circuit's decision "directly conflicts with the statutory scheme and with other circuits." Pet. 12. Petitioner's argument is wrong.

First, Section 501 refers to the denial of benefits notice issued by the plan administrator. Petitioner never claimed in this lawsuit that the Explanation of Benefits ("EOB") denying Mr. Murray's claims did not satisfy Section 501. She could not do so. The EOBs clearly explained that Mr. Murray's claims for benefits were denied because "CHARGES INCURRED AS A RESULT OF AN ON THE JOB INJURY OR ILLNESS ARE DENIED ACCORDING TO THE MAJOR MEDICAL EXCLUSIONS IN YOUR SUMMARY PLAN DESCRIPTION." Second, neither the District Court nor the Fifth Circuit ever addressed whether the EOBs denying Petitioner's claims complied with ERISA because Petitioner never raised this issue. Rather, Petitioner intermingles this new argument with her mistaken assertion that a plan exclusion is an affirmative defense that a plan administrator must specifically plead in its answer or it is waived, which is the point that she appealed to the Fifth Circuit.

Third, in rejecting Petitioner's affirmative defense/waiver argument, the Fifth Circuit concluded that the work-related exclusions were unambiguous in this case, and that the District Court did not err in concluding that the work-related exclusion defense was not waived because Petitioner was

neither surprised nor prejudiced by Respondents' reliance on the exclusion. The Fifth Circuit affirmed that:

> The record reflects that Petitioner was on notice of the work-related exclusion in the SPD prior to the filing of the lawsuit. Petitioner concedes that the defendants asserted the work-related exclusion in their June 11, 2003 Motion to Limit Discovery, filed over 11 months before the trial setting. Furthermore, defendants affirmatively pled in their answer to Murray's Second Amended Complaint that the claims were denied in accordance with the terms and conditions of the Plan.

Pet. App. 5. Additionally, Petitioner testified that she understood nearly two years before she filed her lawsuit that Mr. Murray's claims were denied because his claims "arose out of an injury that occurred in the course and scope of an occupation for wage or profit." Resp. App. 20b, 21b, 22b.

E. The outcome of this case would be the same under *de novo* review.

Even if a court reviewed Petitioner's denial of benefits claim under a *de novo* standard of review, the decision to deny benefits is correct based on the plain and unambiguous terms of the Plan. The Plan specifically excludes from coverage injuries arising out of or in the course and scope of employment for wage or profit. Resp. App. 2b, 10b. Petitioner submitted a handwritten statement to the claims administrator specifically stating that "yes," Mr. Murray's claims were incurred in the course and scope of employment, and testified that Mr. Murray's injuries occurred during his occupation for wage or profit. Resp. App. 11b, 12b, 13b, 19b, 20b. Given these undisputed facts, applying a *de novo* standard of review would not change the outcome in this case.

II. THE COURT SHOULD DECLINE TO CONSIDER PETITIONER'S CHALLENGE TO THE REASONABLE EXPECTATIONS DOCTRINE.

Petitioner claims that the Fifth Circuit erred in its "rejection (by affirmation) of the reasonable expectations doctrine," and that the courts of appeals are divided over whether ERISA plans must be interpreted in accordance with the doctrine and ERISA plan administrators' decisions reviewed under the doctrine. Pet. i. As the District Court noted, under the doctrine of reasonable expectations, "even an unambiguous exclusion may be unenforceable unless it is sufficiently clear, plain and conspicuous to overcome a layperson's reasonable expectations." Pet. App. 14 (quoting *Saltarelli v. The Bob Baker Group Med. Trust*, 35 F.3d 382, 385-87 (9th Cir. 1994)).

A. The District Court correctly concluded that the reasonable expectations doctrine would not apply to the work-related exclusion in this case.

Petitioner argues that the District Court erroneously concluded (and the Fifth Circuit erroneously affirmed the conclusion) that the reasonable expectations doctrine would not apply in this case. This Court's Rules provide that "[a] petition for a writ of certiorari is rarely granted when the asserted error consists of erroneous factual findings . . .." SUP. CT. R. 10. In this case, there are no exceptional circumstances that would justify further review of the District Court's conclusion that, "even if the Court adopted the doctrine of reasonable expectations, the exclusion was plain, clear and sufficiently conspicuous." Pet. App. 16.

Consistent with the District Court's conclusion, the courts of appeals that have considered the reasonable expectations doctrine in the context of an ERISA plan have, either explicitly or implicitly, held that application of the doctrine

requires a threshold determination that the plan exclusions are not sufficiently "clear, plain and conspicuous" or are ambiguous. *Saltarelli*, 35 F.3d at 387 (applying the doctrine because the exclusion was not "clear, plain and conspicuous"); *see also Bynum v. CIGNA Healthcare of N.C., Inc.*, 287 F.3d 305, 313-14 (4th Cir. 2002) (if a plan is ambiguous, court will then interpret it in accordance with the insured's reasonable expectations); *Pirkheim v. First Unum Life Ins.*, 229 F.3d 1008, 1011 (10th Cir. 2000) ("Where the insuring clause or exclusionary provision is conspicuous, clear and unequivocal, we conclude application of the common law doctrine of reasonable expectation is improper"); *McClure v. Life Ins. Co. of N. Am.*, 84 F.3d 1129, 1136 (9th Cir. 1996) ("if the exclusionary language . . . in question is conspicuous it would bar recovery. . ."); *Babikian v. Paul Revere Life Ins. Co.*, 63 F.3d 837, 842 (9th Cir. 1995) (plaintiff had no reasonable expectation that her plan benefits would vest because plan provisions were "clear, plain and conspicuous"); *Wheeler v. Dynamic Eng'g, Inc.*, 62 F.3d 634, 638 (4th Cir. 1995) ("Where a term is ambiguous," court looks at reasonable expectations); *Winters v. Costco Wholesale Corp.*, 49 F.3d 550, 555 (9th Cir.), *cert. denied*, 516 U.S. 908 (1995) (plaintiff "had no objectively reasonable expectation of coverage" for a medical procedure because plan's exclusionary clauses were conspicuous, plain and clear); *Peterson v. Am. Life & Health Ins. Co.*, 48 F.3d 404, 411-12 (9th Cir.), *cert. denied*, 516 U.S. 942 (1995) (reasonable expectations doctrine does not apply because exclusion of bypass surgery was not ambiguous and was sufficiently conspicuous).

1. The SPD Exclusions are clear, plain and conspicuous.

The District Court concluded that the work-related exclusions were sufficiently clear, plain and conspicuous to survive any reasonable expectations attack. Both the District Court and the Fifth Circuit concluded that the work-related exclusions are unambiguous. Pet. App. 5, 16.

Both SPDs describe the exclusion in language that is calculated to be understood by an average plan participant. Specifically, the GPA SPD clearly explains that, "Charges arising out of or in the course of any occupation for wage or profit," are not covered by the Plan. Resp. App. 10b. Similarly, the CIGNA SPD states plainly that: "No payment will be made for expenses incurred for you or any of your Dependents . . . for or in connection with an injury arising out of, or in the course of, any employment for wage or profit." Resp. App. 2b.

In addition, the exclusions are in no way "minimized, rendered obscure or otherwise made to appear unimportant" and they are "described or summarized in a manner not less prominent than the style, captions, printing type, and prominence used to describe or summarize plan benefits." 29 C.F.R. § 2520.102-2(b). In the GPA SPD, the Table of Contents identifies, "MAJOR MEDICAL PLAN EXCLUSIONS AND LIMITATIONS" in the same manner as the section for "MAJOR MEDICAL EXPENSE BENEFITS" and all other Table of Content titles. Resp. App. 5b, 6b. Turning to the section on Exclusions, the page is titled, **"MAJOR MEDICAL PLAN EXCLUSIONS AND LIMITATIONS"** and, under **"GENERAL EXCLUSIONS AND LIMITATIONS"** has a numbered list of items that are not covered under the Plan. Resp. App. 10b. The "occupation for wage or profit" exclusion is the third listed,

is described in a separate paragraph, and is written in the same font, type and style used to describe the Plan benefits and all other provisions in the SPD. Resp. App. 10b.

Similarly, the CIGNA SPD's Table of Contents references "General Limitations" in the same manner used to identify other SPD sections, including the preceding sections on benefits. Resp. App. 1b. In the **"GENERAL LIMITATIONS MEDICAL AND VISION BENEFITS"** section, the exclusion for charges incurred in "any employment for wage or profit" is set forth in a separate, bullet pointed paragraph. Resp. App. 2b. In fact, it is the very first exclusion listed. Finally, the font, style and type used for the exclusion are the same used to describe benefits and are used throughout the SPD.

Based on the language in these SPDs, even applying *Saltarelli*'s reasonable expectations doctrine, the District Court's conclusion was sound. In *Saltarelli*, in contrast to the exclusions in this case, the exclusion at issue was found in the middle of the plan's Definitions section and, even in that section, understanding the exclusion required a coordinated reading of three separate definitions. 35 F.3d 382, 385 (9th Cir. 1994). Although the plan had a section entitled, "Exclusions and Limitations," unlike here, the pre-existing condition exclusion was not identified in that section. *Id.* Significantly, the language and placement of the CROSSMARK SPD exclusions have none of the flaws that existed with the pre-existing condition exclusion in *Saltarelli*. *See also Babikian*, 63 F.3d at 842 (finding that plaintiff had no reasonable expectation that her plan benefits would vest because plan provisions were "clear, plain and conspicuous"); *Winters*, 49 F.3d at 555 (holding that plaintiff "had no objectively reasonable expectation of coverage" for a medical procedure because plan's exclusionary clauses, which were

identified in appropriate Table of Contents headings, were conspicuous, plain and clear).

2. The GPA SPD's work-related exclusion is not ambiguous.

Both the District Court and the Fifth Circuit concluded that the work-related exclusion in both SPDs was unambiguous. Pet. App. 5, 16. Nonetheless, Petitioner argues that the GPA SPD exclusion is ambiguous "as to whether it applies to worker's compensation coverable injuries or all work-related injuries" and that the exclusion should, therefore, be construed in accordance with her expectations of coverage. Pet. 15. This argument is unpersuasive given the clear, unambiguous language of the GPA SPD.

The Sixth Circuit rejected the same argument in *Marquette Gen. Hosp. v. Goodman Forest Industries*, 315 F.3d 629 (6th Cir. 2003). In *Marquette*, the Sixth Circuit applied ERISA to the same type of work-related exclusion at issue in this case. *Id.* at 631-32. The plan in that case, like the GPA SPD, excluded "claims arising out of, or in any course of any occupation or employment for wage or profit or claims for which the covered person is entitled to benefits under any Workers' Compensation or occupational disease law . . .." *Id.* at 631-32. The Sixth Circuit easily rejected the plaintiffs' argument that this clause was ambiguous and that the "or" in the exclusion should be read as "and." *Id.* at 632-33. The Sixth Circuit explained:

> This exclusion is written in the disjunctive; one exclusion does not depend on the other, nor does one determine the other. Contrary to Plaintiffs' assertion, the word **or** does not also mean **and**. Any other reading constrains the clear meaning of the language. As this court has previously held, ERISA plans should

> be interpreted "according to their plain meaning, in an ordinary and popular sense."

Id. at 633 (citation omitted) (emphasis in original). Thus, the Sixth Circuit found that the denial of benefits was "rational" and "neither arbitrary or capricious" and upheld the district court's summary judgment. *Id.* Likewise, the determination by the District Court and Fifth Circuit that the exclusion is unambiguous is proper.

3. The CIGNA SPD's pre-existing condition exclusion is not ambiguous and Petitioner waived this argument.

Attempting to create ambiguity where none exists, Petitioner contends that the work-related exclusion in the CIGNA SPD is ambiguous because the SPD also has a pre-existing condition exclusion. Pet. 15.

Petitioner's pre-existing condition argument fails at the outset because she did not raise this argument at the administrative review level or in the District Court. It is well established that, absent exceptional circumstances that would result in a miscarriage of justice, a party cannot appeal a summary judgment based on theories or factual claims that were not presented to the trial court or court of appeals. *See Williams*, 504 U.S. at 41; *Lawn,* 355 U.S. at 362 n.16; *California v. Taylor*, 353 U.S. at 556 n.2.

Moreover, because the administrators did not rely on a preexisting condition exclusion to deny charges resulting from Mr. Murray's work-related injuries, Petitioner's argument fails. In short, the exclusions are conspicuous and unambiguous and, under well-established ERISA precedent, the District Court correctly granted summary judgment.

B. The Fifth Circuit did not reject the reasonable expectations doctrine.

Petitioner's argument that there is a split of authority over application of the reasonable expectations doctrine is wrong. The Fifth Circuit's decision in this case does not reject the reasonable expectations doctrine. The District Court's summary judgment Order did not adopt the reasonable expectations doctrine. Pet. App. 15. It nonetheless analyzed whether the doctrine, if recognized, would save Petitioner's claim. Pet. App. 15-17. In its decision affirming the District Court's summary judgment, the Fifth Circuit did not specifically analyze Petitioner's reasonable expectations argument. The Fifth Circuit concluded that the work-related exclusions were "unambiguous" and affirmed the District Court's summary judgment on Petitioner's "denial of benefits claim essentially for the well-stated reasons provided by the district court." Pet. App. 5-6.

C. The courts of appeals are not split with respect to the reasonable expectations doctrine.

Petitioner claims that the Second Circuit, Third Circuit,[4] Fourth Circuit and Ninth Circuit have accepted the reasonable expectations doctrine, that the Fifth Circuit and Tenth Circuit have found it inapplicable to ERISA, and that the Seventh Circuit has not decided the issue. Pet. 14-15. A careful

---

[4] The 1992 Third Circuit opinion upon which Petitioner relies involves a different legal question. *Henglein v. Informal Plan for Plant Shutdown Benefits for Salaried Employees*, 974 F.2d 391 (3d Cir. 1992). Unlike this case, *Henglein* did not address the standards for reviewing the meaning of plan exclusions. Rather, *Henglein* merely held that, in determining whether a plan *exists*, courts should determine whether a reasonable person could ascertain the elements of a plan. *Id.* at 401. It is only in this context that the Third Circuit refers to ERISA's purpose of protecting a plan participant's reasonable expectations. *Id.*

review of the circuit court decisions referencing reasonable expectations (including the cases cited by Petitioner) does not reveal any split of authority between the Tenth Circuit and Fifth Circuit, on the one hand, and the other circuits referenced by Petitioner, on the other hand.[5]

The Ninth Circuit first applied the "reasonable expectations" doctrine to an ERISA-governed insurance contract in the case of *Saltarelli v. The Bob Baker Group Medical Trust*, 35 F.3d 381, 387 (9th Cir. 1994).[6] *Saltarelli* concluded that a pre-existing condition exclusion that was found in the middle of the plan's Definitions section (as opposed to the "Exclusions and Limitations" section) and that could only be understood based on a coordinated reading of three separate definitions "was not clear, plain and conspicuous enough to negate layman Saltarelli's objectively reasonable expectations of coverage." *Id.* at 387. Significantly, *Saltarelli* did not specify whether the plan at issue afforded discretion to the administrator or whether the district court had applied an abuse of discretion or *de novo* review to the determination. In addition, *Saltarelli* made clear that it was not holding that the reasonable expectations doctrine would apply in every ERISA case. To the contrary, the Ninth Circuit specifically stated: "We leave comprehensive delineation of the doctrine's scope to future cases." *Id.* at 387, n. 8. Subsequent Ninth Circuit decisions

---

[5] Other than the Ninth Circuit, the circuit courts that have referenced the "reasonable expectations" doctrine in the ERISA context have done so briefly with either no or limited analysis of the doctrine's scope. In addition, most circuit courts have only applied the doctrine in cases in which the ERISA plans at issue do not afford plan administrators with discretion to interpret the plan.

[6] Prior to *Saltarelli*, circuit courts had only "obliquely" addressed the issue. *Saltarelli*, 35 F.3d at 386, n.5.

confirm the narrow application of the doctrine. *See, e.g.*, *Estate of Shockley v. Alyeska Pipeline Svc. Co.*, 130 F.3d 403, 407 (9th Cir. 1997) ("extending the doctrine to ERISA pension plans would be inconsistent with circuit and Supreme Court precedent requiring abuse of discretion review of a retirement committee's actions"); *Winters*, 49 F.3d at 554-55 (reasonable expectations doctrine does not apply as part of a consideration of whether an employer/administrator abused its discretion in interpreting a plan exclusion); *Winterstein v. Stryker Corp. Group Life Ins. Plan*, 157 F. App'x 20 (9th Cir. 2005) ("To the extent ambiguity is found in the plan's provision . . ., upon *de novo* review we must construe that ambiguity in favor of [the plaintiff]. Both the doctrine of *contra proferentem* and the doctrine of reasonable expectations require that.").

The other circuit courts that have mentioned the reasonable expectations doctrine have generally referenced it in the context of cases involving *de novo* review, or have found no need to analyze it because it clearly did not apply. For example, in *Gallagher v. Reliance Standard Life Insurance Co.*, the Fourth Circuit held: "If a plan does not clearly grant discretion, the standard of review is de novo. . . . Any ambiguity in an ERISA plan 'is construed against the drafter of the plan, and it is construed in accordance with the reasonable expectations of the insured.'" 305 F.3d 264, 269 (4th Cir. 2002) (quoting *Bynum v. CIGNA Healthcare of N.C., Inc.*, 287 F.3d 305, 313-14 (4th Cir. 2002)) (internal citation omitted). *See also Wheeler*, 62 F.3d at 638 (considering the insured's reasonable expectations only after determining that the plan did not give the administrator discretion to interpret it).

The Second Circuit has likewise not engaged in any detailed analysis of the application of the reasonable expectations doctrine in the ERISA context. In *Lifson v. INA*

Life Insurance Co., the Second Circuit merely mentions that plan terms "must be construed in accordance with the reasonable expectations of the insured." 333 F.3d 349, 353 (2d Cir. 2003)(citations omitted). In *Lifson*, the defendants were not provided discretion under the plan and, therefore, the plan administrator's decision was reviewed *de novo*. *Id.* at 352. Thus, the Second Circuit has not applied the doctrine to cases in which the administrator has discretionary review under the plan and *Lifson*'s brief mention of the doctrine provides no indication that the Second Circuit would do so.

Similarly, in *Ruttenberg v. United States Life Insurance Co.*, the Seventh Circuit only referenced consideration of a beneficiary's reasonable expectations in a footnote. 413 F.3d 652, 668, n. 19 (7th Cir. 2005). Importantly, however, *Ruttenberg* involved a *de novo* review that afforded "no deference to U.S. Life's interpretation of contract terms." *Id.* at 660. Based on the Seventh Circuit's limited reference to the doctrine in the context of a case involving *de novo* review, there is no indication that the Seventh Circuit would find that the doctrine applied in an abuse of discretion setting.[7]

In attempting to demonstrate that a conflict exists among the circuits, Petitioner asserts that the Fifth Circuit (in this case) and the Tenth Circuit have rejected the reasonable expectations doctrine. As noted previously, however, the Fifth Circuit did not reject the reasonable expectations

---

[7] In a footnote in *Carr v. Reliance Standard Life Insurance Co.*, the Sixth Circuit references a plaintiff's argument that his reasonable expectations concerning a plan's interpretation should apply. 363 F.3d 604, 607 n.3 (6th Cir. 2004). Without analyzing the argument, the court equated the argument to a *contra proferentum* rule that only applies to ambiguous terms and, for support, cited an earlier Sixth Circuit case that addressed *contra proferentum* but did not address reasonable expectations. *Id.* (citing *Marquette Gen. Hosp.*, 315 F.3d at 632 n.1).

doctrine in this case. Similarly, the Tenth Circuit decision to which Petitioner points does not expose any conflict. *Kimber v. Thiokol Corp.*, 196 F.3d 1092 (10th Cir. 1999). To the contrary, the Tenth Circuit relied on the Ninth Circuit's *Estate of Shockley* decision in concluding that the doctrine did not apply in that case. *Id.* at 1101. Specifically, the Tenth Circuit held that, in a case in which the administrator was afforded discretion to interpret the terms of an ERISA plan, "[a]llowing a beneficiary's expectations under the plan to dominate an administrator's interpretation would obliterate the discretionary review required by *Firestone*." *Id.* (citing *Estate of Shockley*, 130 F.3d 403, 407 (9th Cir. 1997)). Thus, the Tenth Circuit held that "the reasonable expectation doctrine is inapplicable to the review of an ERISA disability benefits plan under the arbitrary and capricious standard." *Id.* In sum, there is no circuit court split on the application of the doctrine of reasonable expectations.

III. GPA AND CIGNA CANNOT BE LIABLE FOR PAYMENT OF BENEFITS UNDER THE PLAN.

Finally, GPA and CIGNA can have no liability to Petitioner on her claim for recovery of benefits under the Plan. Petitioner appears to believe that GPA and CIGNA are insurers that have somehow provided insurance benefits under the Plan. The SPD explicitly states the Plan is self-insured by CROSSMARK, and GPA and CIGNA provide claims administration services to the Plan. Resp. App. 3b, 4b, 8b, 9b.

CROSSMARK was and is the only Plan administrator of the Plan, which is self-funded by CROSSMARK. GPA and CIGNA were not the Plan administrator, nor were they the Plan's insurer. Resp. App. 3b, 4b, 8b, 9b. GPA and CIGNA were merely third-party claims administrators with which CROSSMARK contracted to assist it in administering benefits

to employees. All payments made under the Plan were made from CROSSMARK funds, not GPA's or CIGNA's.

The Second Circuit has encountered this very situation, in a case filed against CIGNA under ERISA. *Lee v. Burkhart*, 991 F.2d 1004, 1006 (2d Cir. 1993). In *Lee*, the employer that provided a self-funded benefits plan filed for bankruptcy, leaving claims unpaid. *Id.* The participants then sued CIGNA, which they believed to be the insurer of the plan. *Id.* The court held that CIGNA had no liability under ERISA for benefits or for failure to provide information because only the plan and its administrator could be liable for such claims under the plan's terms. *Id.* at 1009-10. *See also Everhart v. Allmerica Fin. Life Ins. Co.*, 275 F.3d 751, 754 (9th Cir. 2001), *cert. denied*, 536 U.S. 826 (2002) (holding claims for benefits can be only against plan); *Layes v. Mead Corp.*, 132 F.3d 1246, 1249 (8th Cir. 1998) (permitting suit against plan administrator but not employer); *Garren v. John Hancock Mut. Life Ins. Co.*, 114 F.3d 186, 187 (11th Cir. 1997) (holding that outside insurance company that serviced plan was not proper defendant because it was not plan administrator); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1490 (7th Cir. 1996) ("ERISA permits suits to recover benefits only against the Plan as an entity. . .") (citation omitted); *Daniel v. Eaton Corp.*, 839 F.2d 263, 266 (6th Cir.), *cert. denied*, 488 U.S. 826 (1988) (holding that only proper party in suit for benefits under ERISA plan is party in control of plan administration).

As a result, GPA and CIGNA cannot be liable to Petitioner for benefits under the Plan.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be denied.

Respectfully submitted,

W. Alan Wright
Counsel of Record
Melissa M. Goodman
Laura E. O'Donnell
HAYNES AND BOONE, LLP
901 Main Street
Suite 3100
Dallas, Texas 75202
(214) 651-5000

Counsel for Respondents
CROSSMARK Sales, Inc. and
Group & Pension Administrators, Inc.

APPENDIX

MURRAY EXHIBIT 8

[p.1]

CROSSMARK, Inc.
Benefits with Choice Plan — PPA
Excerpt

[p.2]

TABLE OF CONTENTS Page

Important Information 8
The Schedule 10
Section 125 Plan 25
How to File Your Claim 27
Eligibility — Effective Date 28
Comprehensive Medical Benefits 34
Prescription Drug Benefits 48
Vision Care Benefits 52
General Limitations 53
Medicare Eligibles 57
Coordination of Benefits 59
Right of Reimbursement 63
Payment of Benefits 64
Termination of Insurance 65
Summary Plan Description 73
Definitions 78

[p.54]

GENERAL LIMITATIONS
MEDICAL AND VISION CARE BENEFITS

No payment will be made for expenses incurred for you or any one of your Dependents:

- for or in connection with an injury arising out of, or in the course of, any employment for wage or profit;

- for or in connection with a Sickness which is covered under any worker's compensation or similar law;

* * *

[p.74]

SUMMARY PLAN DESCRIPTION

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

Plan Type

The Plan is a health care benefit plan.

Type of Administration

The Administrator of the Plan shall have the full power to control and manage all aspects of the Plan in accordance with its terms and all applicable laws. The Administrator may allocate or delegate its responsibilities for the administration of the Plan to others and employ others to carry out or give advice with respect to its responsibilities under the Plan. Various aspects of the Plan are administered by CG and subsidiaries of CIGNA

Healthplan, Inc. Service of legal process may also be made upon a Plan Trustee (if any).

* * *

[p.78]

SUMMARY PLAN DESCRIPTION

CG will provide administrative services of the following nature: Claim Administration; Cost Containment; Financial; Banking and Billing Administration.

Benefits provided under this plan are self-insured by the Employer.

This document is issued by:

Connecticut General Life Insurance Company
900 Cottage Grove Road
Hartford, CT 06152

If you have questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

MURRAY EXHIBIT 5

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR CROSSMARK, INC. EXCERPT

PURPOSE

It is the intention of the Plan Administrator, CROSSMARK, Inc., to hereby establish a program of benefits constituting a self-funded "Employee Welfare Benefit Plan" under the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments thereto.

IN WITNESS WHEREOF, the Plan Administrator has executed, and the Claims Administrator has acknowledged, this Plan Document as of the Plan effective date shown herein.

The effective date of the Plan is January 1, 1997. Restated January 1, 1999.

* * *

TABLE OF CONTENTS

	PAGE
GENERAL INFORMATION	3
ERISA	4
INTRODUCTION	5-6
SCHEDULE OF BENEFITS	7-12
OUT-OF-AREA BENEFIT	13
VISION CARE PLAN	14
PRESCRIPTION DRUG PLAN	15-16
HOSPITAL ADMISSION PRE-CERTIFICATION AND CONCURRENT REVIEW	17
NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT	17
MEDICAL CASE MANAGEMENT/LARGE CASE MANAGEMENT	18
SECOND SURGICAL OPINION	18
PRE-EXISTING CONDITION EXCLUSION LIMITATION	19
PORTABILITY AND CREDITABLE COVERAGE	20
COMPREHENSIVE MEDICAL BENEFITS	21-22
MAJOR MEDICAL EXPENSE BENEFITS	23-26
MAJOR MEDICAL PLAN EXCLUSIONS AND LIMITATIONS	27-29
SCHEDULE OF DENTAL AND ORTHODONTIC BENEFITS	30-41
COORDINATION OF BENEFITS	42
COORDINATION PROCEDURES	43-44
COORDINATION WITH MEDICARE	44
SUBROGATION	44
CLAIM FILING	45
APPEAL OF CLAIM	46
ELIGIBILITY FOR COVERAGE	47-48
EFFECTIVE DATE OF COVERAGE	49

EMPLOYEE AND DEPENDENT	49-50
SPECIAL ENROLLMENT PERIODS	
LATE ENROLLEE	51
ANNUAL LATE ENROLMENT PERIOD	52
COVERAGE CHANGES	52
BENEFIT CHANGES	53
TERMINATION OF COVERAGE	53
COVERAGE DURING LEAVE OF ABSENCE	53
REINSTATEMENT OF COVERAGE	54
REPLACEMENT OF GROUP MEDICAL COVERAGE	54
FAMILY AND MEDICAL LEAVE	55
COBRA	56-57
GENERAL PROVISIONS	58-59
DEFINITIONS	60-71

[p.3]

GENERAL INFORMATION

This Plan Document describes the benefits for the Employees of CROSSMARK, Inc. and its subsidiaries and affiliates.

This statement is required by the Employee Retirement Income Security Act of 1974 (ERISA) and provides important information regarding your rights under this law.

Group to Which This Statement Applies
CROSSMARK, Inc.
6400 International Parkway
Plano, Texas 75093

Plan Administrator/Plan Sponsor
CROSSMARK, INC.
6400 International Parkway
Plano, Texas 75093
972-349-1322

Type of Plan
Self-Funded Welfare
Benefit Plan

Agent for Service of Legal Process
Rodger L. Fisher, Vice President
CROSSMARK, Inc.
6400 International Parkway
Plano, Texas 75093
972-349-1322

Claims Administrator
Group & Pension Administrators, Inc.
300 Municipal Drive
Richardson, Texas 75080
972-238-7900

Regional Office of Pension and Welfare Benefit Administration
Pension and Welfare Benefits Administration (PWBA), Department of Labor
Dallas Regional Office
525 Griffin Street, Rm 707
Dallas, Texas 75202-5025
214-767-6831

Plan Year
January 1 through December 31 of the same year

Employer Tax ID Number
75-2670784

IRS Plan ID Number
501

* * *

[p.5]

INTRODUCTION

CROSSMARK, Inc., hereinafter referred to as "Employer", hereby establishes a self-funded Employee Welfare Benefit Plan hereinafter referred to as the "Plan"; the rights and privileges of which shall pertain to Employees and their Dependents with respect to such Plan. The benefits are to be provided under the Plan through funds contributed by the Employer and Employees.

PURPOSE

The purpose of the Plan Document is to set forth the provisions of the Plan which provide for the payment or reimbursement of all or a portion of Covered Medical Expenses and Covered Dental Expenses.

EFFECTIVE DATE

The effective date of the Plan is January 1, 1997 as of 12:01 a.m. Restated January 1, 1999.

* * *

NAMED FIDUCIARY

The named Fiduciary is CROSSMARK, Inc., who shall have the authority to control and manage the operation and administration of the Plan. The Employer may delegate responsibilities for the operation and administration of the Plan. The Employer or Board of Directors of the Employer shall have the authority to amend the Plan, to determine its policies, to appoint and remove service providers, adjust their

compensation (if any), and exercise general administrative authority over them. The Employer has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder.

* * *

[p.27]

MAJOR MEDICAL PLAN EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to expenses incurred by all Covered Persons:

GENERAL EXCLUSIONS AND LIMITATIONS

* * *

3. Charges arising out of or in the course of any occupation for wage or profit, or for which the Covered Person is entitled to benefits under any Worker's Compensation or Occupational Disease Law, or any such similar law.

* * *

MURRAY EXHIBIT 1

GROUP & PENSION ADMINISTRATORS, INC.
300 Municipal Drive Richardson, TX 75080
(972)238-7900 Fax (972)669-8155

May 11, 2001

NEVA J. MURRAY
8910 GOLDEN BROOK
SAN ANTONIO TX 78250

EMPLOYER ID: M870033
CERTIFICATE: 0251

RE: HUGH MURRAY
EMPLOYEE: NEVA MURRAY

We have received a claim for the above-referenced person and are in the process of evaluating for payment. In order to correctly process this claim, we need the following information from your records:

The claim indicates the services were provided for treatment of an injury or accident on 2-12-01. Please provide a complete description of exactly how, where and when this injury or accident took place:

Fell from Attic through ceiling to concrete floor over garage,
Where: 8570 Dawnwood, San Antonio, Tx 78750
When: 2-12-01 in the afternoon

Also, please fill out the following:

Was the accident related in any way to your work?

Yes

If yes, please explain:

Was on job. Self employed - Admiral Pest Control, 7126 Eckhert Rd. Ste 211, San Antonio, 78238, (210) 647-1508

Was the accident the result of a third party?

Not Sure

Name and address of third party insurance company:

We do not have other Ins.

If a police report was made, please include a copy of the name and address of the Police Department:

I don't think so.

Your attention to this request is important since all charges are pending the receipt of this information. Thank you for your assistance. If you have any questions, please contact our Customer Service Department. We sincerely appreciate your cooperation in this matter.

* * *

_____I will be pursuing a claim against the third party(s) who caused, contributed to, or aggravated said injury or accident. The name, address, and phone number o the attorney who will represent me is attached.

_____I will not be pursuing a claim against the third party(s).

XXX I am not sure at this time.

I hereby warrant that I have take no action to defeat said Plan's subrogation rights.

Signed /s/ Neva Murray Date 5-29-01
HUGH MURRAY, or Participating Employee if dependent child.

Subscribed and sworn before me on this 29 day of May, 2001.

/s/ Judith F. Cline
NOTARY PUBLIC

I, Neva Murray, wife of Hugh Murray is signing this due to my husband Hugh Murray is not able to sign at this time.

MURRAY EXHIBIT 18

Johnnie Kay Monk
Claim Service Consultant

CIGNA
Routing 244
600 East Taylor
Sherman TX 75414
Telephone 903.870.2724
Facsimile 903.893.7059
johnnie.monk@cigna.com

August 13, 2001

NEVA MURRAY
8910 GOLDEN BROOK
SAN ANTONIO, TX 78250

RE: Hugh Murray
Group # 25192
Employer: Crossmark

Dear Ms. Murray:

We regret to inform you that CIGNA HealthCare cannot process claims going forward on your spouse's file relating to the injury incurred on 2/1/01. CIGNA should not have covered these charges due to the following exclusion listed under the General Limitations in your Summary Plan Description:

No payment will be made when charges are received for or in connection with an injury arising out of, or in the course of, any employment for wage or profit.

If you'd like to discuss this matter further, you may do so by contacting CIGNA HealthCare. We value your business and truly want to be of service. With your insurance certificate number (listed above) ready as a reference, please call me toll free at 1.800.525.5803 ext. 2724, any business day.

Sincerely,

/s/ Johnnie Kay Monk
Johnnie Kay Monk

MURRAY EXHIBIT 36

Debra Shires
Proclaim Correspondence
Sherman Customer Service

CIGNA
Routing 244
P.O. Box 188013
Sherman TX 75090
Telephone 1.903.870.2691
Facsimile 1.903.868.9599
shires@cigna.com

November 5, 2001

NEVA S MURRAY
8910 GOLDEN BROOK
SAN ANTONIO, TX 78250

Dear:

Connecticut General Life Insurance Company, on behalf of your Employer Plan Denial of Level One Medical Necessity Appeal
Insured ID #: 454-11-3500

Dear Mrs. Murray:

After reviewing your request and all supporting documentation, I have decided to uphold the original decision to deny your claims as occupationally related. This decision was based on the following:

This was a result of an injury or illness where wages were being received. This is exclusion under your plan.

I regret that this response is not more favorable. If you are not satisfied with this decision, you may request a second level appeal review by the Appeals Committee. This Committee will include physician(s) who where not involved in any previous review of your issue. If you decide to continue with a second level appeal review, please promptly send your request and any additional supporting documentation, which you think the Committee, should review to:

Designated Appeal Unit
Attn: Appeals Coordinator
P.O. Box 188015
Chattanooga, TN 37422-8015

Sincerely,

/s/ Debra Shires
Debra Shires

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

CIVIL ACTION NO. SA-03-CA-0085

NEVA MURRAY	)
Plaintiff,	)
	)
VS.	)
	)
CROSSMARK SALES, INC.,	)
CONNECTICUT GENERAL LIFE	)
INSURANCE COMPANY, A/K/A	)
CIGNA HEALTHCARE; AND	)
GROUP & PENSION	)
ADMINISTRATORS, INC.,	)
Defendants.	)
	)

ORAL AND VIDEOTAPED DEPOSITION OF
NEVA MURRAY
November 7, 2003
Excerpt

* * *

[p.15]

* * *

Q. Well, let me rephrase that and see if I can -- because I want to know what your claims are. Are your claims -- you're claiming that the defendants wrongfully denied benefits

to you under the CROSSMARK health plan based on medical expenses related to Mr. Murray's injury on February 12th of 2001?

A. Yes. The denial of the insurance, yes.

Q. Okay. The denial of benefits to pay for expenses that have arisen from Mr. Murray's February 12th, 2001 injury?

A. Yes.

Q. Okay. I'd like to talk a little bit about Mr. Murray's injury. And I'm going to refer to your husband as Mr. Murray, if that's okay.

A. Okay.

Q. Mr. Murray's February 12th, 2001 injury [p.16] occurred while he was performing his job; correct?

A. While he was working, yes.

Q. Okay. And could you describe the details of how -- or explain how, to your knowledge, Mr. Murray was injured on that day?

A. He was working in the attic of a house and he fell through the ceiling over the garage onto the garage floor, concrete floor.

Q. And the reason he was at this house was because he was performing pest control services for the tenant of that house?

A. Yes.

Q. Okay. And do you recall the location or the tenant?

A. No. I don't remember at this time, no.

Q. Okay. And Mr. Murray was at that location to perform pest control services for which he would have received payment?

A. Yes.

* * *

[p.88]

* * *

Q. Okay. What's the date of Exhibit 18?

A. August 13th, 2001.

Q. Okay. And CIGNA stated that it regretted to inform you that CIGNA HealthCare cannot process claims going forward on your spouse's file relating to the injury incurred on February 1, 2001?

A. Yes.

Q. CIGNA should not have covered these charges due to the following exclusion listed under the general limitations in your summary plan description. And then it sets forth the exclusion as no payment will be made when charges are received for or in connection with an injury arising out of or in the course of any employment for wage or profit. Do you see that?

A. Uh-huh.

Q. Okay. And when you received Exhibit 13, you understood that CIGNA was denying your claims under the CROSSMARK medical plan from that point forward?

A. Right. That was the beginning of me knowing [p.89] all about this. That's the beginning of me knowing about the exclusions.

Q. When you received this letter?

A. Uh-huh.

Q. Yes?

A. Yes.

Q. Okay. And you understood from Exhibit 18 that the reason CIGNA was denying your claims for benefits under the CROSSMARK medical plan was because of the general limitation in the plan set forth in this letter?

A. I understood what the letter said.

Q. Okay. The exclusion being no payment will be made when charges are received for or in connection with an injury arising out of or in the course of any employment for wage or profit; correct? You understood that --

A. I understood at that time. I didn't know about this until August.

Q. Okay. All I'm asking is when you received this letter, you understood it?

A. Yes. I understood what it said.

Q. Okay. And you understood that that was the reason CIGNA was denying your claims for benefits related to Mr. Murray's injury?

A. Yes. I understood that's what the reason was.

* * *

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

CIVIL ACTION NO. SA-03-CA-0085

NEVA MURRAY, INDIVIDUALLY AND AS GUARDIAN OF HUGH MURRAY, WARD, Plaintiffs,	)
V.	)
CROSSMARK SALES, INC.; CONNECTICUT GENERAL LIFE INSURANCE COMPANY, A/K/A CIGNA HEALTHCARE; AND GROUP & PENSION ADMINISTRATORS, INC., Defendants.	)

ORAL DEPOSITION OF
CHERYL GRAHAM
November 20, 2003
Excerpt

The ORAL DEPOSITION OF CHERYL GRAHAM, was taken by Plaintiffs before April C. Presley, a Certified Shorthand Reporter, in and for the State of Texas, at the offices of Crossmark Sales, Inc. 5100 Legacy Drive, City of Plano, County of Collin, State of Texas, between the hours of 9:13 a.m and 2:36 p.m. on the 20th day of November 2003, pursuant to the Federal Rules of Civil Procedure and the agreements hereinafter set forth.

* * *

[p.44]

* * *

A. The schedule of benefits changed, not the plan document. But the schedule of benefits changed from February 12th, 2001, to March 1st, 2001.

Q. Were those changes in writing, or did somebody set those changes down in writing?

A. Yes.

Q. Where would that be? Would that be -- what document would that be in, the changes?

A. The changes? It's in the enrollment guide. And there were other communication pieces in the open enrollment packet that also talked about the changes.

* * *

[p.52]

* * *

Q. Is that a true, complete, and correct copy of the Plan Document and Summary Plan Description for Crossmark that became effective March 1, 2001?

A. Yes, it looks like it is.

* * *

[p.53]

* * *

Q. When did the Plan Document and Summary Plan Description marked as Deposition Exhibit 1 cease to apply to the claim submitted by Mrs. Murray on behalf of her husband?

A. The schedule of benefits changed on March 1st, but the actual plan language stayed in place until this one was published, which was late June or July of 2001.

* * *

(2)

No. 05-1350

FILED

JUN 26 2006

OFFICE OF THE CLERK
SUPREME COURT, U.S.

In The

Supreme Court of the United States

NEVA MURRAY, Individually and
as Guardian of Hugh Murray, Ward,

Petitioner,

v.

CROSSMARK SALES, INC.; CONNECTICUT GENERAL LIFE INSURANCE CO.; and GROUP & PENSION ADMINISTRATORS, INC.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

CONNECTICUT GENERAL LIFE INSURANCE COMPANY'S BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

SCOTT KING FIELD
Counsel of Record
LARRY F. YORK
YORK, KELLER & FIELD, L.L.P.
816 Congress Avenue, Suite 1670
Austin, Texas 78701
(512) 867-1616

Counsel for Respondent
Connecticut General Life Ins. Co.

COCKLE LAW BRIEF PRINTING CO. (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTIONS PRESENTED

1. Should this Court accept Murray's invitation to review the Fifth Circuit's unpublished, per curiam opinion and judgment to reconsider its well-established precedent in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), upon which numerous employers have based the language of their employee welfare benefit plans with regard to the discretion granted to claims administrators over the last 17 years, based on an argument that was never raised before the district court or court of appeals, and in a case in which an unambiguous plan exclusion clearly precludes recovery?

2. Should this Court decide whether the doctrine of reasonable expectations applies in ERISA denial-of-benefits cases in this case, in which the court of appeals, in its unpublished decision, never wrote on that issue and where the prerequisites for application of the doctrine – an ambiguous or inconspicuous plan exclusion – are not present?

3. Should this Court accept review of a case in which two of the Respondents – Group & Pension Administrators and Connecticut General Life Insurance Company – cannot be held liable for benefits to Murray because they did not serve as plan administrator and were merely third-party claims administrators of Crossmark Sales, Inc.'s self-funded plan?

PARTIES TO THE PROCEEDINGS BELOW

Pursuant to SUP. CT. R. 24.1(b), Respondent Connecticut General Life Insurance Company identifies the following parties to the proceeding in the court whose judgment is under review:

A. Petitioner is Neva Murray, Individually and as Guardian of Hugh Murray, Ward.

B. Respondents are Connecticut General Life Insurance Company; Crossmark, Inc.; and Group & Pension Administrators, Inc.

CORPORATE DISCLOSURE STATEMENT

Pursuant to SUP. CT. R. 29.6, Respondent Connecticut General Life Insurance Company identifies the following potentially interested parties who are related to it: CIGNA Corporation, which is a publicly held corporation, CIGNA Holdings, Inc., and Connecticut General Corporation.

TABLE OF CONTENTS

	Page
QUESTIONS PRESENTED	i
PARTIES TO THE PROCEEDINGS BELOW	ii
CORPORATE DISCLOSURE STATEMENT	iii
TABLE OF CONTENTS	iv
TABLE OF AUTHORITIES	v
INTRODUCTION	1
STATEMENT OF THE CASE	2
I. Facts from the Appellate Record	2
II. Petitioner's Material Misrepresentations of the Appellate Record	7
REASONS FOR DENYING THE PETITION	9
I. The Court should not revisit its decision in *Firestone* because Petitioner has waived this argument and has shown no compelling reason for the Court to grant review	9
II. This is not an appropriate case for deciding whether the doctrine of reasonable expectations should apply in all ERISA denial-of-benefits cases	18
III. CGLIC cannot be liable for payment of benefits under the plan	22
CONCLUSION	25

TABLE OF AUTHORITIES

Page

CASES

Aetna Health Inc. v. Davila, 542 U.S. 200 (2004) 9

Allianz Versicherungs, AG v. Profreight Brokers, Inc., 99 Fed. Appx. 10 (5th Cir. 2004) 16

Allied Chem. Corp. v. Mackay, 695 F.2d 854 (5th Cir. 1983) 15

Ball Corp. v. Xidex Corp., 967 F.2d 1440 (10th Cir. 1992) 15

Blum v. Spectrum Restaurant Group, Inc. a/k/a NBACO, Inc., 261 F. Supp.2d 697 (E.D. Tex. 2003) 24

Bull's Corner Restaurant, Inc. v. Director of Federal Emergency Management Agency, 759 F.2d 5002 (5th Cir. 1985) 16

Daniel v. Eaton Corp., 839 F.2d 263 (6th Cir.), *cert. denied*, 109 S.Ct. 76 (1988) 24

Everhart v. Allmerica Financial Life Ins. Co., 275 F.3d 751 (9th Cir. 2001), *cert. denied*, 122 S.Ct. 2662 (2002) 24

Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989) 1, 17

Garren v. John Hancock Mut. Life Ins. Co., 114 F.3d 186 (11th Cir. 1997) 24

Holloway v. HECI Exploration Co. Employees' Profit Sharing Plan, 76 B.R. 563 (N.D. Tex. 1987), *aff'd, Matter of HECI Exploration Co. Inc.*, 862 F.2d 513 (5th Cir. 1988) 24

TABLE OF AUTHORITIES – Continued

Page

Jass v. Prudential Healthcare Plan, Inc., 88 F.3d 1482 (7th Cir. 1996) 24

Johnson v. Cullen, 925 F. Supp. 244 (D. Del. 1996) 15

Kleinknecht v. Gettysburg College, 989 F.2d 1360 (3d Cir. 1993) 15

Layes v. Mead Corp., 132 F.3d 1246 (8th Cir. 1998) 24

Lee v. Burkhart, 991 F.2d 1004 (2d Cir. 1993) 23, 24

Marquette General Hosp. v. Goodman Forest Indus., 315 F.3d 629 (6th Cir. 2003) 19

Moore, Owen, Thomas & Co. v. Coffey, 992 F.2d 1439 (6th Cir. 1993) 15

Murphy v. Wal-Mart Assocs.' Group Health Plan, 928 F. Supp. 700 (E.D. Tex. 1996) 24

Peterson v. Air Line Pilots Ass'n Int'l, 759 F.2d 1161 (4th Cir.), *cert. denied*, 474 U.S. 946 (1985) 15

Salterelli v. Bob Baker Group Medical Trust, 35 F.3d 382 (9th Cir. 1994) 20, 21

Stephens v. C.I.T. Group/Equipment Financing, Inc., 955 F.2d 1023 (5th Cir. 1992) 19

U.S. v. United Foods, Inc., 533 U.S. 405 (2001) 11, 19

Vermont Mutual Ins. Co. v. Everette, 875 F. Supp. 1181 (E.D. Va. 1995) 15

Vogel v. Veneman, 276 F.3d 729 (5th Cir. 2002) 19

STATUTES

29 U.S.C. § 1002(16)(A)(ii) 23

29 U.S.C. § 1002(16)(B)(i) 23

TABLE OF AUTHORITIES – Continued

Page

29 U.S.C. § 1132(c) 6, 12

Fed. R. Civ. P. 8(c)..... 13, 14, 15

INTRODUCTION

Petitioner Neva Murray was a participant in Respondent Crossmark Sales, Inc.'s ("Crossmark") employee welfare benefit plan, which, since 1997, has contained an exclusion for work-related injuries. Murray enrolled her husband in the plan as a dependent on March 29, 2000. Murray admits her husband was injured while on the job in February 2001 and that the plan contains an exclusion for work-related injuries. These facts are fatal to Murray's claim, and it was on this basis that Respondent Group & Pension Administrators ("GPA") and Respondent Connecticut General Life Insurance Company ("CGLIC"), the claims administrators for Crossmark's plan during the relevant time period, denied benefits.

Recognizing the effect of these undisputed facts, Murray turns to arguments not made to the court of appeals or the district court and based on purported facts not present in the appellate record. Murray argues that even if the plan document grants a claims administrator discretion, the abuse of discretion standard should not necessarily apply. Murray requests that this Court overturn its decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), 17 years after it was decided and during which time nearly every employer in the United States that offers benefits to its employees has followed the Court's direction in deciding the amount of discretion to confer to plan fiduciaries. Murray requests such relief for the first time in this Court, and she does so in the absence of any conflict among the circuits on this issue.

Murray also requests that the Court decide whether the doctrine of reasonable expectations applies in all ERISA denial-of-benefits cases. Lost in Murray's argument

is the fact that this issue was not discussed by the court of appeals in its opinion and judgment, which was not published. Thus, even if there were disagreement among the circuits, this case does not provide an appropriate platform for addressing any such conflict. In addition, the plan exclusion at issue was conspicuous and unambiguous. For the doctrine of reasonable expectations to apply in any circuit, a finding of either lack of conspicuousness or ambiguity is required. Thus, even if this case otherwise provided a vehicle for deciding whether the doctrine of reasonable expectation applies, the facts of the case do not lend themselves to full consideration of the issue.

For these reasons and those stated below, CGLIC respectfully submits that the Court should not grant Murray's petition.

STATEMENT OF THE CASE

I. Facts From the Appellate Record

Neva Murray is an employee of Crossmark and has participated in an employee welfare benefits plan offered by Crossmark, which includes medical benefits, since 1996. Pet.'s App. 2. The plan is self-funded. *Id.* The summary plan description ("SPD") and the plan document are contained in one document and control the terms of the plan. (Box of Exs.: Pl. Depo. Exs. 5, 8; Graham Depo. at 14-16, 57; Huth Depo. at 30).

Crossmark is the plan administrator, but it delegates claims administration to third-party claims administrators that have discretion and authority to make benefit determinations. Pet.'s App. 2. In 1997, GPA became the claims

administrator for the plan. CGLIC replaced GPA on March 1, 2001, and the SPD was amended in July 2001. *Id.*

Since at least 1997, the plan has excluded work-related injuries from coverage. The GPA SPD[1] provides an exclusion for

> Charges arising out of or in the course of any occupation for wage or profit, or for which the Covered Person is entitled to benefits under any Worker's Compensation or Occupational Disease Law, or any such similar law.

Pet.'s App. 3. Similarly, the CGLIC SPD provides:

> No payment will be made for expenses incurred for you or any one of your Dependents: for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit.

Id.

On March 29, 2000, Neva Murray ("Murray" or "Mrs. Murray") enrolled her husband as a dependent beneficiary of the plan. Pet.'s App. 2. On February 12, 2001, Mr. Murray fell through an attic ceiling onto a concrete floor while performing his pest control job for profit. Pet.'s App. 3. Mr. Murray suffered severe head injuries, requiring extensive medical care.

---

[1] The plan referred to in this brief is the Crossmark Medical Plan, which was provided for the benefit of Crossmark's employees. GPA acted as claims administrator for the plan until March 1, 2001 and was replaced by CGLIC. For ease of reference, the SPD under which GPA administered claims and which was in effect until July 2001 is referred to herein as the "GPA SPD." Thereafter, it is referred to herein as the "CGLIC SPD."

As part of GPA's investigation of the claims relating to this accident, it sent Mrs. Murray a request for information, to which she responded on May 29, 2001. Pet.'s App. 3. In her response, Mrs. Murray admitted her husband's injuries were work-related.

> Was the accident related in any way to your work? *Yes*
>
> If yes, please explain: *Was on job. . . . Self employed – Admiral Pest Control 7126 Eckhert Rd. Ste 211, San Antonio; 78238.*

Id.; (*see also* Box of Exs.: Pl. Depo. Ex. 1; Pl. Depo. at 18-19).

Based on this information, GPA determined that Mr. Murray's injuries were work-related and, therefore, excluded from coverage under the plan's work-related exclusion. Pet.'s App. 3. Crossmark then reviewed GPA's denial of Murray's claims and concurred that Mr. Murray's injuries were excluded because they were work-related. *Id.*

Unlike GPA, CGLIC utilizes what it calls a "pay and chase" system of claims administration. Pet.'s App. 4. Under this system, as a general rule, CGLIC initially pays claims that it receives, and then conducts an investigation to determine whether the claims are covered under the plan it is administering. Pet.'s App. 4. If a claim is ultimately denied, CGLIC seeks reimbursement on behalf of the plan for the benefits paid. (Box of Exs.: Graham Depo. at 96-97; Huth Aff. ¶ 3). Based on this system, CGLIC initially paid approximately $90,000.00 in benefits related

to Mr. Murray's injury. Pet.'s App. 4.[2] CGLIC employed Primax Recoveries Incorporated ("Primax") to investigate whether Mr. Murray's medical claims were covered by the plan. (Box of Exs.: Huth Depo. at 33-34; Pl. Depo. at 81; Pl. Depo. Exs. 16, 17). On June 21, 2001, Primax sent Mrs. Murray a request for information, and in August 2001, contacted her by telephone to determine whether her claims were covered by the Plan. (Box of Exs.: Pl. Depo. at 79-83; Pl. Depo. Exs. 16, 17). Mrs. Murray told Primax that Mr. Murray's injuries were work-related. (Box of Exs.: Pl. Depo. at 80-81).

Around this same time, Crossmark notified CGLIC that, based on Crossmark's review of the claims, it had learned that the claims were work-related. (Box of Exs: Graham Depo. at 99-100). When CGLIC discovered that Mrs. Murray admitted that Mr. Murray's injuries were work-related, it also began denying claims arising out of Mr. Murray's work-related injuries pursuant to the plan terms. (Box of Exs.: Pl. Depo. at 88-91, 97, 100-101; Pl. Depo. Exs. 18, 19, 20, 22, 35; Huth Depo. at 32; Huth Aff. ¶ 5).

Murray appealed GPA's and CGLIC's denial of her claims on the ground that Mr. Murray did not have workers' compensation insurance, but she failed to present GPA and CGLIC with evidence showing that Mr. Murray's injuries were not work-related, leading to affirmance of the previous claim denials. (Box of Exs.: Pl. Depo. at 104-107, 161-163, 173-176, 188, 190; Pl. Depo. Exs. 23, 35, 42,

[2] The district court referred to GPA as having made an initial payment of benefits to Murray. (Pet.'s App. 17 & Rec. 568-69). CGLIC, however, is the entity that originally paid Murray's claims until it realized they were work-related.

43, 45; Straughan Aff. ¶¶ 10, 11 and Exhibit 1 (CM 00392-429); Huth Aff. ¶¶ 6, 7 and Exhibit 1 (CGLIC 1977-2046)). Mrs. Murray then filed this suit.

Murray filed suit in the U.S. District Court for the Western District of Texas, San Antonio Division. The case was assigned to Honorable Edward C. Prado and then reassigned to Honorable Xavier Rodriguez. Because Appellees' denial of benefits to Murray based on the unambiguous language of the plan exclusions was neither arbitrary nor capricious, Crossmark and GPA filed a motion for summary judgment on February 24, 2004. Pet.'s App. 9. CGLIC filed a Motion for Leave to join Crossmark and GPA's motion for summary judgment, which was granted on July 2, 2004. *Id.* Murray filed a Motion for Partial Summary Judgment on February 27, 2004. *Id.*

On July 22, 2004, the district court denied Mrs. Murray's motion for partial summary judgment and granted a complete summary judgment for GPA and CGLIC. Pet.'s App. 9-22. The district court granted summary judgment to Crossmark on Murray's denial of benefits claim but found that Murray had raised a claim under 29 U.S.C. § 1132(c), and that fact issues existed with respect to that claim. *Id.* By stipulation, that claim was dismissed with prejudice on September 30, 2004, and it is not part of this appeal. Pet.'s App. 7. On October 4, 2004, the district court entered a final judgment. Pet.'s App. 7-8.

Murray then appealed the district court's judgment to the Fifth Circuit. The Fifth Circuit affirmed by an unpublished, per curiam opinion and judgment on January 23, 2006. (Pet.'s App. at 1-6).

II. Petitioner's Material Misrepresentations of the Appellate Record

Consistent with Rule 15.2 of this Court's Rules, CGLIC notes the following misrepresentations of the appellate record by Petitioner Murray. The judgment of the trial court and the court of appeals was based on cross-motions for summary judgment, and only those facts contained in the summary judgment record may be considered on appeal to this Court.

Murray states on page 3 of the Petition that "once CIGNA assumed administrative duties on March 1, 2001, it administered the Crossmark plan without benefit of any governing documents – whether SPD or plan – until July, 2001." This is a misstatement of the evidence in the record. As indicated above, the record indicates that CGLIC indeed became the claims administrator for the Crossmark plan on March 1, 2001, but there was no amendment of the plan that GPA had been administering at that time. Thus, CGLIC administered claims under the GPA SPD until the plan was amended in July 2001, at which time CGLIC used the CGLIC SPD – which contained a substantively identical work-related exclusion to the GPA SPD – in administering claims.

Page 5 of Murray's petition contains one of the grossest misstatements of the record contained in the petition. Murray indicates that "CIGNA, months after learning of Mr. Murray's extensive claims, drafted its plan, separated out the worker's compensation and work-related exclusions into two separate exclusions, and placed the work-related exclusion as the first-listed one." This statement is untrue and does not appear anywhere in the appellate record. In fact, CGLIC's SPD, which was an amendment to

the Crossmark Plan in July 2001, was drafted with no regard to Murray's claims and was a form used by CGLIC that contained the same work-related exclusion as the GPA SPD; the CGLIC SPD merely listed the exclusion separately rather than in a single paragraph with the workers' compensation exclusion like the GPA SPD. Murray grossly misstates the record in this regard and in fact bases a large portion of her petition on the purported fact that CGLIC used a backdated or post-hoc plan document to apply to her claim. This representation is untrue and is not in the appellate record.

Additionally, Page 6 of the Petition contains facts that are not found in the appellate record. Murray states, without support, that "Respondents indicated, in internal communications, that no administrator was to pay any benefits for Hugh Murray and instructed adjusters to deny all claims, in an apparent decision that all future health care needs by Mr. Murray related back to his accident. Claims for Mr. Murray's gastrointestinal and cardiac problems were thus denied." This purported representation of facts appears nowhere in the appellate record. In fact, Murray first attempted to make such a claim after the district court granted summary judgment to Respondents. The district court granted Crossmark's motion to strike this pleading (Rec. 638-640), and Murray did not appeal the district court's actions.

These misstatements by Petitioner should not be considered by this Court when deciding whether to grant Murray's petition.

REASONS FOR DENYING THE PETITION

Murray contends that the Court should grant review in this case consistent with concerns raised by Justice Ginsburg in her concurring opinion in *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004). Justice Ginsburg's opinion in *Davila*, however, has nothing to do with the facts or law presented in this case. Justice Ginsburg decried the preemptive effect of ERISA on potential state-law remedies and the resulting failure to provide a "make-whole standard of relief." *Id.* at 224.

Preemption is not an issue in this case, nor does this case involve an inability to be made whole under ERISA because of limitations within the statutory remedies provided by Congress. Rather, Murray had an opportunity to be made whole through ERISA-based remedies under Section 502(a); however, an exclusion existed under the plan's terms that clearly precluded her recovery.

Murray, however, ignores the concrete nature of the facts of this case and the applicable plan language in an attempt to entice the Court into accepting review of an unremarkable case decided in an unpublished Fifth Circuit opinion that affirmed an unpublished order of the district court, granting summary judgment for the Respondents.

I. The Court should not revisit its decision in *Firestone* because Petitioner has waived this argument and has shown no compelling reason for the Court to grant review.

Murray begins her argument by asking the Court to consider whether a claims administrator granted full discretion under an applicable plan document should

nevertheless have its benefit decisions under the plan reviewed *de novo* under factual circumstances Murray contends are present here. CGLIC respectfully submits that there is no compelling reason for the Court to accept review to decide this issue for several reasons. First, the facts Murray claims justify such a variance on the level of discretion granted by the plan are not present in the appellate record. Second, Murray never raised this argument in the courts below and should not be allowed to present this argument for the first time to this Court while attacking the judgment of the courts below. Finally, there is no split of authority among the circuits on this issue that necessitates resolution by this Court.

Murray first requests that the Court decide the question of "whether a backdated or post-hoc instrument may exclude claims for benefits under an ERISA welfare benefit plan, as Respondents have done here." (Pet. at 10). As detailed above, this issue, as presented, assumes facts that are not in the appellate record. Respondents applied no backdated or post-hoc plan document to Murray's claims. Instead, the GPA SPD, in effect at the time of Murray's enrollment in the plan and the time of Mr. Murray's injuries, was in effect until July 2001. GPA administered claims for the plan until March 2001, at which time CGLIC took over as claims administrator. Then, in July 2001, the plan was amended. Neither CGLIC nor GPA applied a backdated or post-hoc plan document to Murray's claims.

Murray also argues that given these purported facts, the Court should consider the question "whether the abuse of discretion review is appropriate under these circumstances." (Pet. at 10). Again, this question, as presented, assumes facts not in the appellate record, as indicated

above. Moreover, Murray never raised any argument concerning the appropriate standard of review in the district court or the court of appeals. In fact, in the district court, Murray filed a cross-motion for summary judgment in which she argued that Respondents abused their discretion in denying her claim. (Pet.'s App. 9 & Rec. 362). Thus, Murray assumed that the abuse of discretion standard applied and never argued that another standard should apply.

This Court has held that when a petitioner fails to raise an argument in the court below that attacks the judgment, the argument will not be considered. *U.S. v. United Foods, Inc.*, 533 U.S. 405, 416-17 (2001). In *United Foods*, the government attempted to raise an argument concerning the immunity of government speech from the normal amount of scrutiny applied. It was undisputed, however, that the government never raised this argument in the court of appeals. *Id.* at 416. The Court concluded that the government's failure to raise this point deprived respondent of the ability to address such matters. *Id.* at 416-17. The Court noted that although respondents are sometimes allowed to defend judgments on grounds other than those pressed in lower courts, it is a different matter when a petitioner attempts to present new substantive arguments attacking a judgment that were not raised in the court below. *Id.* at 417.

Likewise, the Court should not allow Murray to raise the issue of the propriety of the abuse of discretion standard of review in ERISA denial-of-benefit cases when she did not dispute that this standard of review applied when the case was before the district court and court of appeals. Murray never raised this argument until she sought review in this Court. Respondent CGLIC, therefore,

respectfully requests that the Court not accept review of Murray's argument concerning the propriety of the abuse of discretion standard as applied under the facts of this case.

However, even if this Court were to address Petitioner's argument, it has no merit. Murray alleges a litany of ideas for why Respondents should not have been afforded discretion in making the claims determination in this case. First, Murray argues that because Respondents allegedly failed to provide Murray with the applicable SPD, Respondents should not be entitled to review under an abuse of discretion standard. This argument ignores the facts of this case. Murray does not dispute that she enrolled in the Crossmark plan in 1996, well before Mr. Murray's accident. She had ample opportunity to review a copy of the plan, which included the worked-related exclusion at issue since 1997, well before Mr. Murray's injuries. Moreover, the SPD was available on-line at her work. Finally, even if one were to accept Murray's argument that she could not access the SPD on-line at work, there is no question that Crossmark provided her with a hard copy no later than August 2, 2001.

If there is any remedy for the conduct Murray alleges occurred – failure to timely provide a copy of the applicable SPD, which is disputed by Crossmark – then the remedy is penalties as provided in 29 U.S.C. § 1132(c), as the district court held here. Murray and Crossmark stipulated to dismissal of that issue. Pet.'s App. 7. Murray suggests, however, that actions taken by the plan administrator – Crossmark – in providing or not providing the SPD to participants in a timely manner should negatively affect the amount of discretion that the claims administrators – GPA and CGLIC – had in interpreting the plan and

assessing claims for benefits under it. There is no logical connection between the issue of whether the plan administrator provided a copy of the SPD to participants in a timely manner and whether the Plan confers discretion on claims administrators in making claims decisions under the plan. Murray's argument ignores the undisputed fact that there was a written SPD that excluded work-related injuries, and that this exclusion was applicable to Mr. Murray's injuries.

Apparently recognizing the deficiency of this argument, Murray then progresses to a confused argument that seems to incorrectly intertwine two unrelated concepts. First, Murray correctly points out that notice must be given to participants of the reason for the denial of a claim. (Pet. at 12). Murray appears to take this fact, however, and assume that the same standard applies to pleading plan exclusions under Rule 8 of the Federal Rules of Civil Procedure. *Id.* at 12-13. CGLIC is uncertain how these two separate requirements relate to the appropriate standard of review in an ERISA denial-of-benefits case, but it will address each and demonstrate how neither rule was violated here and why the facts of this case do not show the need for imposition of a *de novo* standard of review, as Murray argues.

First, Murray contends that Respondents failed to provide adequate notice of the reasons for their denial of Murray's claim such that she did not know that they would claim application of the work-related exclusion. This is not true. In fact, Respondents could not have been more explicit in denial letters sent to Murray well over a year before she filed the underlying suit. In early August 2001, GPA began issuing Explanation of Benefits ("EOBs")

to Murray denying all claims arising out of Mr. Murray's February 12, 2001 injury because:

> "CHARGES INCURRED AS A RESULT OF AN ON THE JOB INJURY OR ILLNESS ARE DENIED ACCORDING TO THE MAJOR MEDICAL EXCLUSIONS IN YOUR SUMMARY PLAN DESCRIPTION."

(Box of Exs.: Pl. Depo. at 97-100; Pl. Depo. Ex. 21; Straughan Depo. at 43-44; Straughan Aff. ¶ 9 and Exhibit 1 (GPA 00001, 18-38)). Likewise, in CGLIC's denial letters sent to Murray at the administrative level, the applicable exclusionary language was explicitly stated. For example, CGLIC's August 13, 2001 denial letter states:

> CIGNA should not have covered these charges due to the following exclusion listed under the General Limitations in your Summary Plan Description:
>
> > *No payment will be made when charges are received for or in connection with an injury arising out of, or in the course of, any employment for wage or profit.*

(Box of Exs.: Pl.'s Depo. Ex. 18 (emphasis in original)). Thus, Murray knew well before she ever filed suit that CGLIC was relying on the work-related exclusion in the plan.

In addition, because Mrs. Murray had the burden of proving that the administrators' decisions to deny the benefit claims was arbitrary and capricious, Respondents were not required to plead the exclusion as an affirmative defense. *See also* FED. R. CIV. P. 8(c). To require otherwise would effectively shift Murray's burden of proof to Respondents, which is contrary to ERISA jurisprudence.

Even assuming Murray is correct that the exclusion had to be pleaded specifically, to hold that CGLIC waived application of the exclusion at issue would ignore the purposes of the defensive pleadings rule and the facts of this case. The rule that failure to plead an affirmative defense results in waiver – Rule 8(c) – is not absolute. "Where the matter is raised in the trial court in a manner that does not result in unfair surprise, however, technical failure to comply precisely with Rule 8(c) is not fatal." *Allied Chem. Corp. v. Mackay*, 695 F.2d 854, 855-56 (5th Cir. 1983). The reason for the requirement of Rule 8 is to put plaintiff on notice of defenses well in advance of trial. If a defendant raises a defense at a pragmatically sufficient time and plaintiff is not prejudiced in putting on his or her case, then there is no waiver. *Id.* Federal courts that have confronted this issue have followed this reasoning. *Kleinknecht v. Gettysburg College*, 989 F.2d 1360 (3d Cir. 1993); *Moore, Owen, Thomas & Co. v. Coffey*, 992 F.2d 1439, 1445 (6th Cir. 1993); *Ball Corp. v. Xidex Corp.*, 967 F.2d 1440, 1444 (10th Cir. 1992); *Peterson v. Air Line Pilots Ass'n Int'l*, 759 F.2d 1161, 1164 (4th Cir.), *cert. denied*, 474 U.S. 946 (1985); *see also Johnson v. Cullen*, 925 F. Supp. 244, 247 n.2 (D. Del. 1996); *Vermont Mutual Ins. Co. v. Everette*, 875 F. Supp. 1181, 1189 n.3 (E.D. Va. 1995).

For example, in *Allied Chemical*, the Fifth Circuit noted that although not pleaded, the defense at issue was raised in the trial court's pretrial order. *Allied Chemical*, 695 F.2d at 856. Based on this fact, the Fifth Circuit concluded that the defendant did not "lie behind the log" and held that the defendant "raised the issue at a pragmatically sufficient time, and Allied was not prejudiced in its ability to respond. Construing the Rules to do substantial justice, we hold that the usury defense was not

waived." *Id.*; *see also Allianz Versicherungs, AG v. Prof-reight Brokers, Inc.*, 99 Fed. Appx. 10, 12 (5th Cir. 2004) (concluding that party suffered no prejudice when limitations defense was raised in pre-trial order, three months prior to trial). In another case, the Fifth Circuit considered the fact that the plaintiff had raised an exclusion in its complaint and had discussed the exclusion in its trial memorandum in concluding that the plaintiff "plainly was not a victim of unfair surprise" and that the exclusion at issue had not been waived. *Bull's Corner Restaurant, Inc. v. Director of Federal Emergency Management Agency*, 759 F.2d 500, 502 (5th Cir. 1985).

As detailed above, Murray has suffered no surprise from Respondents' reliance on the work-related exclusion. The exclusion was prominently detailed in the denial letters Respondents sent to Murray well over a year before she filed suit. In addition, in August 2001, Crossmark participated in a conference call with Murray, in which its representatives explained the application of the exclusion to Murray. (Box of Exs.: Graham Aff. ¶ 6).

Also, CGLIC and the other Respondents put Murray on notice that this exclusion was the basis for their denial of Murray's claim during the course of the underlying litigation. CGLIC pleaded the applicability of ERISA to this action, which Murray does not dispute. Pet.'s App. 5. Moreover, CGLIC pleaded that Murray's claims were not covered under the plan. *Id.* In addition, in Crossmark and GPA's Motion to Limit Discovery, filed on June 11, 2003, they asserted the work-related exclusion. *Id.* In fact, Murray herself raised the exclusion in her July 2, 2003 response to the Motion to Limit Discovery. (Rec. 141-42). Respondents again raised the exclusion in their Motion to Strike Plaintiff's Designation of Fact and Expert Witnesses on October

3, 2002. (Rec. 267-68). Again, Murray herself noted this reliance on the exclusion in her response to the motion. (Rec. 278, 281). The trial court's February 5, 2004 order cited the exclusion as the basis for Respondents' denial of Murray's claim. (Rec. 331). Murray also took the deposition of CGLIC's corporate representative, Cynthia Huth, in which Ms. Huth stated explicitly that the sole basis for denial of Murray's claims was the applicability of the exclusion in the GPA and CGLIC Plans. (Box of Exs.: Huth Depo. at 32-34). Witnesses from GPA and Crossmark testified likewise. (Box of Exs.: Graham Depo. at 81-82).

In other words, Murray had fair notice that CGLIC, GPA, and Crossmark would argue the applicability of the work-related exclusion to this case. To claim surprise such that a different standard of review should apply to the claim decisions in this case completely ignores the facts in the appellate record. Murray clearly knew that Respondents would allege the applicability of the exclusion – otherwise, Murray would not have known to raise waiver of the exclusions preemptively in her own Motion for Partial Summary Judgment. (Rec. 362-76).

In sum, Murray does not present the type of facts that should lead this Court to depart from its previous decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), that if a plan conveys discretion on an administrator, then it should be allowed such discretion rather than have its decisions reviewed *de novo*. There is no split of authority among the circuits on this issue and no compelling reasons to justify accepting review of the Fifth Circuit's unpublished, per curiam opinion.

II. This is not an appropriate case for deciding whether the doctrine of reasonable expectations should apply in all ERISA denial-of-benefits cases.

Murray's second primary argument is that the Court should accept review of this case to resolve a conflict among the circuits on whether to adopt the doctrine of "reasonable expectations" in ERISA denial-of-benefits cases. This case, however, is not an appropriate one for resolving this conflict, assuming one exists. The Fifth Circuit did not discuss or even mention the reasonable expectations doctrine in its opinion. In addition, the Fifth Circuit's opinion was unpublished. Only the district court's order made any mention of the reasonable expectations doctrine, and, although the court rejected application of this doctrine, its opinion was unpublished, as well. Thus, even if the Court wished to decide whether the reasonable expectations doctrine has any place in the review of ERISA denial-of-benefits cases, this case would not be the appropriate platform from which to render such a decision.

Moreover, the facts of this case do not lend themselves to resolving this issue. As indicated in Murray's petition, the reasonable expectations doctrine has been applied in two primary circumstances by some circuits – when plan language is ambiguous and when a plan exclusion is not clear and conspicuous. (Pet. at 13-14). Neither circumstance is present here.

As held by the court of appeals, neither the GPA SPD nor the CGLIC SPD is ambiguous. (Pet.'s App. at 5). They clearly exclude benefits for any person who is injured while on the job. The only difference between the GPA and CGLIC SPDs is that while the CGLIC SPD separates the work-related exclusion from the workers' compensation

exclusion, the GPA SPD puts the two exclusions into one clause, separated by the word "or." This fact does not make the GPA SPD ambiguous. The word "or" is plainly disjunctive. There is nothing ambiguous about the language used.[3] Therefore, there is no basis to look beyond the plain language of the SPDs at issue because the exclusions are not ambiguous.

Tellingly, Murray does not even argue that the language of the CGLIC SPD is ambiguous where the exclusion's language is concerned. Instead, she argues that the exclusion became ambiguous in operation because Mr. Murray's injuries became a "pre-existing condition" once the CGLIC SPD was put in place. (Pet. at 15). This argument does not demonstrate an ambiguity that should be read against CGLIC. Murray's "pre-existing condition" argument is not only nonsensical, it has been waived. Murray never raised this issue at the administrative level or in the trial court; as a result, this argument cannot be properly raised for the first time on appeal. *United Foods*, 533 U.S. at 416-17, 121 S.Ct. at 2341; *Vogel v. Veneman*, 276 F.3d 729, 733 (5th Cir. 2002); *Stephens v. C.I.T. Group/Equipment Financing, Inc.*, 955 F.2d 1023, 1026 (5th Cir. 1992).

Moreover, even had this argument not been waived, it makes no sense. The CGLIC SPD does not even mention

---

[3] *See Marquette General Hosp. v. Goodman Forest Indus.*, 315 F.3d 629 (6th Cir. 2003) ("The exclusion is written in the disjunctive; one exclusion does not depend on the other, nor does one determine the other. Contrary to Plaintiffs' assertion, the word or does not also mean and. Any other reading constrains the clear meaning of the language. As this court has previously held, ERISA plans should be interpreted "according to their plain meaning, in an ordinary and popular sense.").

pre-existing conditions. Murray argued to the Fifth Circuit, however, that "Since the CIGNA plan unquestionably provides coverage for preexisting conditions, Mrs. Murray reasonably expected her claim to be paid." (Brief of Appellant at 17). She then referenced a letter from Crossmark indicating to employees that "pre-existing limitations" were removed when the CGLIC SPD came into effect. *Id.* In essence, Murray appears to argue that because the GPA SPD contained a pre-existing condition limitation and the CGLIC SPD did not, then any condition not already existing at the time of the transition from the GPA SPD to the CGLIC SPD would be covered under the CGLIC SPD.

In addition to lacking logic, this argument ignores the basic fact that, even in the absence of an exclusion for pre-existing conditions, the CGLIC SPD still contained applicable exclusions, as did the GPA SPD, one of which squarely applied to Murray's claim. The issue of pre-existing conditions is really a non-issue and is a red herring that Murray failed to raise in the district court.

Murray's other argument for imposition of the reasonable expectations doctrine in this case is that the exclusion at issue was not conspicuous in the CGLIC SPD. The genesis of Murray's argument comes from a Ninth Circuit case, *Salterelli v. Bob Baker Group Medical Trust*, 35 F.3d 382, 387 (9th Cir. 1994). In *Salterelli*, the exclusion on which the defendant relied to deny coverage to the plaintiff was not contained with the other exclusions in the plan document. *Id.* at 385. Instead, it was contained in the "Definitions" section, and three definitions had to be read in conjunction to figure out the scope of the exclusion. *Id.* Based on these facts, the Ninth Circuit decided, as an issue of "first impression," whether the doctrine of reasonable expectations, which applied to insurance contracts

under California law, should be applied in an ERISA case. *Id.* at 386-87. The court concluded that under the circumstances of that case, this doctrine should apply absent a plain, conspicuous statement of the exclusion in the plan document. *Id.* at 387.

As recognized by the district court in this case, the facts of *Salterelli* are not even close to the facts of this case. In *Salterelli*, the exclusion at issue was buried in the definitions section of the plan – and was not even clear among the definitions – rather than appearing with the rest of the plan's exclusions. That is not the case here. CGLIC's exclusions were not hidden at all. The exclusion at issue in the CGLIC SPD was the first exclusion, plainly listed under the heading **"GENERAL LIMITATIONS, MEDICAL AND VISION CARE BENEFITS"**. (Box of Exs.: Pl. Depo. Ex. 8 at 54). There was no hiding of this exclusion among other policy provisions.

Murray suggests that CGLIC hid its exclusions by calling them "General Limitations" and because the page reference to them is incorrect in the SPD's Table of Contents. (Pet. at 5). The SPD's Table of Contents lists General Limitations as appearing on Page 53. Instead, they are listed on Page 54. This typographical error did not mislead Plaintiffs or hide the applicable exclusion. It is plainly listed as the first exclusion on the next page. Moreover, the term "General Limitations" is not misleading in any way; it accurately describes the plan's exclusions. These facts do not even approach the type of facts contained in *Salterelli*. The exclusionary language of the plans is plain and unambiguous, and it was not hidden.

Moreover, Murray had no reason to believe that Mr. Murray's injuries were covered under these circumstances.

The work-related exclusion had been in place since 1997. Pet.'s App. 15. And, Murray is not arguing that coverage that once existed was taken away. The exclusion at issue was always applicable, and CGLIC began denying coverage as soon as facts were revealed that indicated the exclusion was applicable. Pet.'s App. 4.

For these reasons, the "doctrine of reasonable expectations" does not apply here, even if it were accepted as the law, making this case an inappropriate vehicle to decide whether this doctrine should be the rule of law in all circuits.

III. CGLIC cannot be liable for payment of benefits under the plan.

Finally, even assuming for the sake of argument that Murray's arguments are correct, CGLIC can have no liability to Murray on her claim for recovery of benefits under the plan. Murray appears to believe that CGLIC is an insurer that has somehow provided insurance benefits under the plan. The plan explicitly states otherwise. On page 9 of the CGLIC SPD, under the heading **"IMPORTANT INFORMATION"**, it is explained to participants that:

> This is not an insured benefit plan. The benefits described in this booklet or any rider attached hereto are **self-insured by CROSSMARK, Inc.** which is responsible for their payment. Connecticut General provides claim administration services to the plan, but Connecticut General does not insure the benefits described.

(Box of Exs.: Pl.'s Depo. Ex. 8 at 9 (CM 00087) (emphasis in original)).

CGLIC was not the administrator of the plan, nor was it the plan's insurer. CGLIC was not the plan administrator under either plan. Crossmark was and is the only plan administrator of the plan, which is self-funded by Crossmark. (Box of Exs.: Graham Depo. at 13; Pl. Depo. at 212; Pl. Depo. Ex. 5 at 3, 5, 7-16, 21-26, 30-39; Pl. Depo. Ex. 8 at 9, 10-25, 35-44, 49-53, 75, 78). The GPA SPD states, on page 1, that

> [i]t is the intention of the Plan Administrator, CROSSMARK, Inc., to hereby establish a program of benefits constituting a self-funded 'Employee Welfare Benefit Plan' under the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments thereto.

(Box of Exs.: Pl.'s Depo. Ex. 5 at 1 (CM 00007)). Although the CGLIC SPD does not explicitly state what party is the plan administrator, ERISA provides that if a plan does not explicitly designate the party that acts as plan administrator, it is assumed to be the employer, which is Crossmark in this case. *See* 29 U.S.C. § 1002(16)(A)(ii); (B)(i). CGLIC was merely a third-party claims administrator with which Crossmark contracted to assist it in administering benefits to employees. All payments made under the plan were made from Crossmark funds, not CGLIC's, (Box of Exs.: Pl.'s Depo. Ex. 8 at 9 (CM 00087)), and CGLIC was not the plan administrator as that term is used under ERISA.

The Second Circuit has encountered this very situation, in a case filed against CGLIC under ERISA. *Lee v. Burkhart*, 991 F.2d 1004, 1006 (2d Cir. 1993). In *Lee*, the employer that provided a self-funded benefits plan went bankrupt, leaving claims unpaid. *Id.* The participants then sued CGLIC, which they believed to be the insurer of the

plan. *Id.* Under these facts, the court held that CGLIC had no liability under ERISA for benefits or for failure to provide information because only the plan and its administrator could be liable for such claims under the plan's terms. *Id.* at 1009-10.

Other federal courts have held likewise under similar circumstances. *See, e.g., Everhart v. Allmerica Financial Life Ins. Co.*, 275 F.3d 751, 754 (9th Cir. 2001), *cert. denied*, 122 S.Ct. 2662 (2002) (holding claims for benefits can be only against plan); *Layes v. Mead Corp.*, 132 F.3d 1246, 1249 (8th Cir. 1998) (permitting suit against plan administrator but not employer); *Garren v. John Hancock Mut. Life Ins. Co.*, 114 F.3d 186, 187 (11th Cir. 1997) (holding that outside insurance company that serviced plan was not proper defendant because was not plan administrator); *Jass v. Prudential Healthcare Plan, Inc.*, 88 F.3d 1482, 1490 (7th Cir. 1996) ("ERISA permits suits to recover benefits only against the Plan as an entity. . . ."); *Lee*, 991 F.2d at 1009 (same); *Daniel v. Eaton Corp.*, 839 F.2d 263, 266 (6th Cir.), *cert. denied*, 109 S.Ct. 76 (1988) (holding that only proper party in suit for benefits under ERISA plan is party in control of plan administration); *Blum v. Spectrum Restaurant Group, Inc. a/k/a NBACO, Inc.*, 261 F. Supp.2d 697, 709 (E.D. Tex. 2003) (holding that only plan is proper party); *Murphy v. Wal-Mart Assocs.' Group Health Plan*, 928 F. Supp. 700 (E.D. Tex. 1996) (allowing no action against claims administrator for recovery of benefits under section 1132(a)(1)(B)); *Holloway v. HECI Exploration Co. Employees' Profit Sharing Plan*, 76 B.R. 563, 570 (N.D. Tex. 1987), *aff'd, Matter of HECI Exploration Co. Inc.*, 862 F.2d 513 (5th Cir. 1988) (citing and agreeing with Ninth Circuit). CGLIC is unaware of any conflict on this issue among the circuits.

The plan at issue was self-funded by Crossmark. (Box of Exs.: Graham Depo. at 13; Pl. Depo. at 212; Pl. Depo. Ex. 5 at 3, 5, 7-16, 21-26, 30-39; Pl. Depo. Ex. 8 at 9, 10-25, 35-44, 49-53, 75, 78). Crossmark paid claims under the plan out of its own funds. CGLIC merely assisted Crossmark with claims administration; it was not the plan administrator. As a result, CGLIC cannot be liable to Murray for benefits under the plan.

This fact is yet another reason why Murray's petition should be denied. Many of the arguments she makes seek to impose liability on the claims administrators, GPA and CGLIC, as if the plan were fully insured by them. The plan is self-funded by Crossmark, making Murray's claim for benefits against CGLIC and GPA of no effect. Like many other facts in the appellate record, Murray omits this one, which is fatal to many of her claims.

CONCLUSION

This case does not present a record upon which this Court should grant review. Murray misstates the factual record throughout her petition and makes many arguments that were not properly preserved in the courts below. In addition, she seeks review of an unpublished decision from the Fifth Circuit, affirming an unpublished decision of the district court. This case does not further divide the circuits on any issue presented, particularly since the court of appeals did not even write on the reasonable expectations issue. As a result, CGLIC respectfully

requests that the Court deny Murray's Petition for Writ of Certiorari.

Respectfully submitted,

SCOTT KING FIELD
Counsel of Record
LARRY F. YORK
YORK, KELLER & FIELD, L.L.P.
816 Congress Avenue, Suite 1670
Austin, Texas 78701
(512) 867-1616
(512) 867-1617 (fax)
Counsel for Respondent
Connecticut General Life
Insurance Company